STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155344	B. WING		03/28/2011
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	8		S HIGHWAY 20 EAST	
LIFE CAI	RE CENTER OF MI	CHIGAN CITY		GAN CITY, IN46360	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000	This visit was fo State Licensure S This visit was do the Investigation IN00087416.	ar a Recertification and Survey. One in conjunction with a of Complaint E. March 21, 22, 23, 24, E. 000236 Er. 155344 E. 00287700 RN. TC. RN. N. RN. e:	F0000	Note: This provider wishes this Plan Corrections to be considered as our credible allegation of compliance. Preparation and /or execution of this Plan of Correction does not constitu admission of agreement by the prov of the truth of the facts alleged or conclusion set forth in the Statemen Deficiencies. The Plan of Correction prepared and/or executed solely because it is required by the provision the Federal and State laws.	of DATE of the dider that of the distribution is the distribution of the distribution
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIC	NATURE	TITLE	(X6) DATE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Facility ID: 000236

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
111,212,111	or conditions	155344	A. BUILDING		03/28/2011
			B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		802 US	HIGHWAY 20 EAST	
LIFE CAI	RE CENTER OF MI	CHIGAN CITY	MICHIG	GAN CITY, IN46360	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
IAG		es reflect state findings	IAG	,	DAIL
		ice with 410 IAC 16.2.			
	citcu iii accordan	ice with 410 IAC 10.2.			
	Quality review 4/04	/11 by Suzanne Williams, RN			
F0157		nediately inform the			
	· ·	vith the resident's physician;			
		fy the resident's legal an interested family			
	•	ere is an accident involving			
		results in injury and has			
	the potential for re				
	_	nificant change in the I, mental, or psychosocial			
		rioration in health, mental,			
	or psychosocial st	atus in either life			
	threatening condit				
		need to alter treatment a need to discontinue an			
		eatment due to adverse			
		to commence a new form			
		decision to transfer or			
	-	dent from the facility as			
	specified in §483.	12(a).			
	-	also promptly notify the			
		own, the resident's legal			
		interested family member nange in room or roommate			
		ecified in §483.15(e)(2); or			
	a change in reside	ent rights under Federal or			
		ations as specified in			
	paragraph (b)(1)	of this section.			
		ecord and periodically			
		ss and phone number of the			
	resident's legal re family member.	presentative or interested			
SS=E	1	rvation, record review	F0157	157	04/27/2011
55 - [the facility failed to		Resident #3 family and physic	ian
		dents' physician and/or		were notified of weight loss on	•
				03/30/11. Resident #6 MD and	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155344	B. WIN			03/28/2	011
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			HIGHWAY 20 EAST		
LIFE CA	RE CENTER OF MI	CHIGAN CITY		1	SAN CITY, IN46360		
					7		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)	+	TAG	,	14	DATE
		rty were notified			family were notified on 03/23/2 Resident #37 MD was notified		
	, ,	nt changes, blood			refusal of therapies on	OI .	
	1 '	neters, episodes of			04/08/11.Resident #61 MD wa	s	
	insomnia, refus	sal of a splint and			notified of blood pressures on		
	therapy service	es and the development			04/08/11.Resident #95 MD wa	s	
	of a bruise for	6 of 25 records			notified of weight gain on		
	reviewed for pl	nysician and family			03/05/11.Resident #144		
		he sample of 40.			sleeplessness was addressed		
		#6, #37, #61, #95, and			nurse practitioner on 03/16/11		
	#144)	"", "" , "" , "" o , "" o , and			All residents have the potential be affected by the same defici-		
	" ' ')				practice. The 24 hour report lo		
		la.			were reviewed For the past 30	-	
	Findings includ	ie:			days to ensure physicians wer		
	l				notified when required. Any		
		for Resident #3 was			issues identified were correcte	-	
	reviewed on 3/	23/11 at 8:40 a.m.			The 24 hour report logs will be		
	Review of the	weight sheet indicated			reviewed by the interdisciplina	ry	
	on 1/4/11, the i	resident weighed 163.8			team M-F during morning	النبيد	
	pounds. The r	esident's weight on			meeting. Physician notification be verified through chart audit		
	2/1/11 was dod	cumented as 150.4			during daily change of condition		
	pounds.				audits. Licensed nursing staff		
	pourido.				in-serviced on 03/28/11,		
	An ontry comp	leted by the Registered			04/06/11and 04/12/11 by Nurs	ing	
		on 2/26/11, indicated			Administration regarding facilit	У	
	1 ' '	·			policy/procedures for		
	, ,	ht 150.4, down 8.1% in			physician/family notification ar		
	1	icant weight loss,			changeof condition in resident condition. The DON/Designee		
	1' '	family notification was			audit 20% of clinical records	vviii	
	requested."				requiring physician notification	on	
					a weekly basis.		
	There was no	documentation in the			Results of these audits will be		
	Nursing Progre	ess Notes and on the			presented at the monthly		
	1 -	ation sheet to indicate			Performance Improvement		
		s family and physician			Committee Meeting for 6 mont		
	had been notifi				Plan to be amended as indicat	iea	
	Tidd Deell Hollii	ou.			per monthly review per PI Committee. Threshold of		
	Indiam decrees 20	DNI #0 0/04/44			compliance will be 95% before	<u> </u>	
	interview with I	LPN #2 on 3/24/11 at			Compilation will be 30 /0 belote	,	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155344	A. BUI	LDING	00	COMPL: 03/28/20	
		100044	B. WIN			03/20/20	011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY		1	HIGHWAY 20 EAST SAN CITY, IN46360		
				ID	1	1	(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
	2:00 p.m., indic	ated that she could not			discontinuing audits.		
	find any physician and family notification based on the RD request				The Director of Nursing is		
					responsible for ensuring ongoi compliance. Compliance date	ng	
	on 2/26/11.				04/27/11		
	Interview with the	he RD on 3/24/11 at					
		ated after all the					
	=	s are reviewed. She					
		nat require physician					
	_	ication on a separate					
	sheet of paper,						
	recommendation	on sheet.					
	Interview with the	he Director of Nursing					
	on 3/25/11 at 1	0:00 a.m., indicated					
	the resident's p	hysician and family					
		otified of the weight					
	loss for the mor	nth of February.					
		Resident #61 was reviewed p.m. The resident's					
		d, but were not limited to,					
	high blood pressu						
	A physician's orde	r dated 1/20/11, indicated					
		d pressure was to be					
		wo weeks. The physician if the resident's blood					
		iter than 160 or less than					
	110.						
	The January 2011	Medication Administration					
	•	licated the resident's blood					
	•	/63 on 1/30/11. There was					
	no documentation physician had bee	to indicate if the resident's					
	priyototari ilaa bee	ii iiodiiod.					
	The February 201	1 MAR, indicated the					

000236

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE S COMPL	
		155344	A. BUILD B. WING	ING		03/28/2	011
	ROVIDER OR SUPPLIER			802 US	DDRESS, CITY, STATE, ZIP CODE HIGHWAY 20 EAST AN CITY, IN46360		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1 -	ID	DROWINERIC DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PF	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
	107/55. Again, the to indicate if the renotified. Interview with Min Coordinator #2 on indicated there was to physician notific on 1/30 and 2/2/11 Interview with the 3/28/11 at 9:45 a.r was to be notified number) blood preand less than 110 resident's physician	ressure on 2/2/11 was ere was no documentation esident's physician had been fimum Data Set (MDS) 3/25/11 at 10:20 a.m., as no documentation related eation of the blood pressures 1. Director of Nursing on m., indicated the physician if the resident's systolic (top essure was greater than 160 a. She further indicated the in had not been notified of pressure less than 110 on					
SS=E	reviewed on 3/2 resident had fra humerus in July was sent to an follow up after resident had se doctor on 8/24/ was to have on work on range upper extremity wrist. The next orthopedic doctor order	for Resident #37 was 23/11 at 9:30 a.m. The actured her right y 2010. The resident orthopedic surgeon for the fracture. The een the orthopedic 10, and the resident cupational therapy of motion for the right y, right elbow, and right appointment to the tor was on 9/23/10,and red physical therapy tal therapy to the right d.			Resident #3 family and physici were notified of weight loss on 03/30/11. Resident #6 MD and family were notified on 03/23/1 Resident #37 MD was notified refusal of therapies on 04/08/11.Resident #61 MD was notified of blood pressures on 04/08/11.Resident #95 MD was notified of weight gain on 03/05/11.Resident #144 sleeplessness was addressed nurse practitioner on 03/16/11. All residents have the potentia be affected by the same deficie practice. The 24 hour report lowere reviewed For the past 30 days to ensure physicians were notified when required. Any issues identified were corrected.	1. of s s by al to ent gs	04/27/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155344	B. WIN			03/28/2011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				HIGHWAY 20 EAST	
LIEE CAI	RE CENTER OF MI	CHICANICITY		1	SAN CITY, IN46360	
LIFE CAI	NE CENTER OF WIN	CHIGAN CHI		MICITIC	SAN CITT, IN40300	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Review of occu	pational therapy and			The 24 hour report logs will be	
	physical therap	y notes for the months			reviewed by the interdisciplina	ry
	of 8/10 and 9/1	0 indicated the			team M-F during morning	I
	resident had re	fused therapy and any			meeting. Physician notification be verified through chart audit	
	treatment to he				during daily change of condition	
		. rigite airii.			audits. Licensed nursing staff	
	Deview of the o	clinical record indicated			in-serviced on 03/28/11,	
					04/06/11and 04/12/11 by Nurs	ing
	there was no de				Administration regarding facilit	y
	_	esident's orthopedic			policy/procedures for	.
		fied the resident had			physician/family notification ar	
	refused therapi	es.			changeof condition in resident	
					condition. TheDON/Designee audit 20% of clinical records	WIII
	Interview with L	PN #1 on 3/23/11 at			requiring physician notification	on
	11:10 a.m indi	cated there was no			a weekly basis.	
	documentation				Results of these audits will be	
		pedic physician was			presented at the monthly	
					Performance Improvement	
		efusal of therapies.			Committee Meeting for 6 month	ths.
	4				Plan to be amended as indicate	ted
		for Resident #144 was			per monthly review per PI	
		23/11 at 1:10 p.m.			Committee. Threshold of	
		ndicated the resident			compliance will be 95% before discontinuing audits.	,
	had complaints	of sleeplessness on			The Director of Nursing is	
	3/8/11 and indic	cated the Ambien (a			responsible for ensuring ongoi	na
	hypnotic) he tal	kes at night time only			compliance. Compliance date	ĭ
	lasts about 3-4	,			04/27/11	
	Δ Physician M	otification Fax Form				
	•	7 p.m. was completed				
		•				
	on the chart an	•				
		ress notes. The form				
		o the physician. The				
		pove information				
	regarding the re	esident's complaints of				
	sleeplessness.					
			-		•	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155344	A. BUIL		00	03/28/2	
		100044	B. WIN		A DDDDGG CITY CTATE TIN CODE	00/20/2	011
NAME OF P	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY		l	SAN CITY, IN46360		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
		ctitioner had reviewed					
		rote a new order for					
	Seroquel (an antipsychotic) 25 milligrams (mg) daily. There was no						
	date on the forr	n.					
		rs dated 3/16/11					
	indicated Seroc	quel 25 mg daily.					
		RN #1 on 3/23/11 at					
	•	ated she routinely					
		e resident during the					
	_	RN also indicated the					
		practitioner was here					
		ne resident's complaint					
	was on 3/16/11	(eight days later).					
	latamiaaa 27	22/44 + 2-20					
		23/11 at 3:30 p.m., with					
		Nursing, indicated the					
	nurse should ha						
		ne doctor in a more					
	timely manner.						
SS=E	5 On 3/21/11	at 10:10 a.m., Resident			157		04/27/2011
		ed sitting in a wheel			Resident #3 family and physic	ian	01/27/2011
		m. There was a bruise			were notified of weight loss on		
		resident's right hand.			03/30/11. Resident #6 MD and		
		approximately 3 cm.			family were notified on 03/23/ Resident #37 MD was notified		
	(centimeters) in	• •			refusal of therapies on	5 1	
		i didiffotor.			04/08/11.Resident #61 MD wa	s	
	The record for I	Resident #6 was			notified of blood pressures on		
		23/11 at 8:04 a.m. The			04/08/11.Resident #95 MD wa	S	
		noses included, but			notified of weight gain on 03/05/11.Resident #144		
	_	to, osteoarthrosis,			sleeplessness was addressed	by	
	Mere Hor miller	ı 10, USICUAI II II USIS,				,	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ((X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE S	(3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155344	A. BUII			03/28/2	011
			B. WIN		ADDRESS CITY STATE ZIR CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
1.155.045		OLUGAN OITV			HIGHWAY 20 EAST		
LIFE CA	RE CENTER OF MI	CHIGAN CITY		MICHIC	GAN CITY, IN46360		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	polymyalgia rh	eumatica, muscle			nurse practitioner on 03/16/11		
	weakness, and	I high blood pressure.			All residents have the potenti		
	The 3/11 Physician Order Statement indicated there was an order for the resident to receive two tablets of				be affected by the same defici		
					practice. The 24 hour report to		
					were reviewed For the past 30 days to ensure physicians were		
					notified when required. Any	-	
	Aspirin 81 milli	grains ually.			issues identified were correcte	ed.	
					The 24 hour report logs will be		
	The 3/11 Nurse				reviewed by the interdisciplina		
	reviewed. Ther	re was no			team M-F during morning		
	documentation	of the physician being			meeting. Physician notificatior		
	notified of the b	oruise to the right hand.			be verified through chart audit		
		physician notification			during daily change of condition		
		g the physician was			audits. Licensed nursing staff	was	
	notified of the b				in-serviced on 03/28/11,	ina	
		Juise.			04/06/11and 04/12/11 by Nurs Administration regarding facili	-	
					policy/procedures for	ıy	
		ved on 3/23/11 at 10:25			physician/family notification ar	nd	
		ndicated she was			changeof condition in resident		
	assigned to ca	re for the resident. The			condition. TheDON/Designee		
	LPN indicated	nursing staff were to			audit 20% of clinical records		
	notify the phys	ician of new bruises			requiring physician notificatior	n on	
		the notification in the			a weekly basis.		
	chart				Results of these audits will be		
	- Criai C				presented at the monthly		
	Mhon intonios	ved on 3/23/11 at 2:00			Performance Improvement	tha	
					Committee Meeting for 6 mon Plan to be amended as indica		
	•	tor of Nursing indicated			per monthly review per Pl	ı c u	
		vare of the bruise to the			Committee. Threshold of		
	resident's right	hand. The Director of			compliance will be 95% before	,	
	Nursing indicat	ted the physician			discontinuing audits.		
	should have be	een notified of the			The Director of Nursing is		
	bruise at the tir	ne it was first			responsible for ensuring ongo	ing	
	observed.				compliance. Compliance date		
					04/27/11		
SS=E	6. The record f	or Resident # 95 was			157		04/27/2011
	reviewed on 3/	23/11 at 11:07 a.m.			Resident #3 family and physic		
	The resident ha	as diagnoses that			were notified of weight loss or		
			<u> </u>		03/30/11. Resident #6 MD and	ر 	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155344 03/28/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 802 US HIGHWAY 20 EAST LIFE CARE CENTER OF MICHIGAN CITY MICHIGAN CITY, IN46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE family were notified on 03/23/11. included, but were not limited to, Resident #37 MD was notified of squamous cell cancer of the neck, refusal of therapies on valvular heart disease, depression 04/08/11.Resident #61 MD was with anxiety, and chronic kidney notified of blood pressures on disease on dialysis. 04/08/11.Resident #95 MD was notified of weight gain on 03/05/11.Resident #144 The resident was admitted to the sleeplessness was addressed by facility on 2/7/11. Review of the nurse practitioner on 03/16/11. resident's weight sheet indicated All residents have the potential to weights as follows: be affected by the same deficient practice. The 24 hour report logs were reviewed For the past 30 2/7/11 220 pounds days to ensure physicians were 2/16/11 230 pounds notified when required. Any 2/23/11 235.8 pounds issues identified were corrected. The 24 hour report logs will be reviewed by the interdisciplinary Review of the form titled "Nutritional team M-F during morning Progress Notes" indicated an entry meeting. Physician notification will dated 2/24/11 written by the be verified through chart audits Registered Dietician. The entry during daily change of condition audits. Licensed nursing staff was indicated, "Wt. (weight) 235.8 lbs, up in-serviced on 03/28/11, 5.6 lbs. this week and up 15.8 lbs. in 04/06/11and 04/12/11 by Nursing past 2 weeks, requested Dr. and Administration regarding facility family be notified, NAS (No added policy/procedures for salt) diet and peritoneal dialysis physician/family notification and continues." changeof condition in residents condition. The DON/Designee will audit 20% of clinical records Review of the Nurse's Notes dated requiring physician notification on 2/23/11 through 3/16/11 indicated the a weekly basis. physician and family were not notified Results of these audits will be presented at the monthly of the resident's weight gain. Performance Improvement Committee Meeting for 6 months. When interviewed on 3/14/11 at 2:27 Plan to be amended as indicated p.m., MDS Coordinator #1 indicated per monthly review per PI the Physician and the resident's Committee. Threshold of compliance will be 95% before family had not been notified of the

000236

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING 00 COMPLI			
		155344	B. WIN	G		03/28/2	011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
				1	HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MIC	CHIGAN CITY		MICHIG	GAN CITY, IN46360		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	weight gain.				discontinuing audits.		
					The Director of Nursing is responsible for ensuring ongoing		
	3.1-5(a)(3)				compliance. Compliance date	''9	
					04/27/11		
F0170		he right to privacy in written					
		ncluding the right to send					
SS=C		ive mail that is unopened.	F.0	170	F170		04/27/2011
33-C		view, the facility failed	FU	01/0	Residents are now receiving mail on		04/2//2011
		was being delivered to			Saturdays.		
		n Saturday. This had			All residents have the potential to be affected by the same deficient practi		
	•	affect the 89 residents			Mail delivery time will be posted on t	he	
	wno were resid	ing in the facility.			monthly resident activity calendar for Saturday mail deliveries.		
					Activity Manager will audit mail week	dy	
	Findings include	e:			for delivery to residents. Staff	,	
		D :1 10 "			in-serviced on 03/28/11, 0406/11 and 04/12/11 for mail delivery.	,	
		ne Resident Council			Results of audit will be presented at		
		23/11 at 1:00 p.m.,			monthly Performance Improvement Committee Meeting for 6 months. Pl	an	
		sidents receive mail			to be amended as indicated per mor		
		h Friday, but they do			review per PI committee. Threshold	of	
	not receive mai	I on Saturday.			compliance will be 95% before discontinuing audits.		
					The Activity Manager is responsible	for	
		ne Activity Director on			ensuring ongoing compliance. Compliance date 04/27/11.		
		p.m., indicated the			Compilation date = 1/2.7.1.1		
		red by the Activity					
	•	nday through Friday.					
		she was the weekend					
	_	vill deliver the mail on					
	•	ever, it was routinely					
	delivered Mond	ay through Friday.					
	3.1-3(s)(1)						
						ļ	
F0223		he right to be free from sical, and mental abuse,					
		ent, and involuntary					
	seclusion.	-, - ·- ···· - ·-···· - ·					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) D		(X3) DATE S	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIC	00	COMPL	ETED
		155344	A. BUII B. WIN			03/28/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF	PROVIDER OR SUPPLIER	8					
LIEE CA		CLUCAN CITY		l	HIGHWAY 20 EAST		
LIFE CA	RE CENTER OF MI	CHIGAN CITY		MICHIGAN CITY, IN46360			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	re l	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
SS=D	sexual, or physical punishment, or invalidation provided and to reviewed for 1 of 4 in the sample of 40. Findings include: The allegation of vives reviewed on 3 incident date was 3 description of the in in the dining room talking in a loud vives and the dining room talking in a loud vives and the watch." The immediate accomplete accomplete and family the preventative in have Social Service and to re-educate resident that she accomplete	voluntary seclusion. eview and interview, the sure each resident was free related to staff to resident tnessed by a dietary 4 allegations of abuse residents reviewed for abuse 0. (Resident #B) erbal abuse for Resident #B /25/11 at 10:30 a.m. The Sunday 9/26/10. The brief ncident was the resident was when a nurse (named), bice, told the resident to eat a not going to lose weight on etion taken was an started, Executive Director e suspended, physician	F0	223	F223 Resident B has been discharged fro facility. The LPN is no longer employ by facility. 2.) All residents have the potential to affected by the same deficient practice. Allegations of abuse will be reported to Indiana Department of Health and investigated immediately ED/Designee. The facility policy on "Reporting Alleged Abuse" was amended to include "failure to repalleged abuse immediately upon occurrence or allegation will result corrective action." 3.) Staff was in-serviced on 03/28/11 04/06/11 and 04/12/11 on types of abuse, reporting abuse, procedures and investigation of abuse by Nursin Administration. Staff will be in-serviced monthly for 3 months a quarterly thereafter on reporting potential abuse immediately to ED/Designee. DON/Designee will audit 24 hour report daily M-F for potential abuse, incidents and accidents and review resident, fam and staff complaints. The ED/DON on call 24 hours a day. The weeker on call manager will have her name posted on the staff assignment she for immediate notification. All new staff will be informed of abuse policies in orientation and in ongoine ducation. 4.) Allegations of abuse will be report to Performance Improvement. Committee monthly. Tracking and trending will be monitored in Performance Improvement. 5.) The DON is responsible for ensu ongoing compliance. Compliance da 04/27/11.	yed be by prt in g and iilly is de eet ing tted	04/27/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CI		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPI	LETED
		155344	A. BUII			03/28/2	011
			B. WIN		DDDEGG GITY GTATE ZID GODE		
NAME OF I	PROVIDER OR SUPPLIE	R		1	ADDRESS, CITY, STATE, ZIP CODE		
				1	HIGHWAY 20 EAST		
LIFE CA	RE CENTER OF M	ICHIGAN CITY		MICHIG	GAN CITY, IN46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	back to clean the	dining room. I heard the					
	, , ,	he always does) and the					
		er (name) came into give					
		ked her to stop crying and if					
		aide will get mad at her and					
	not put her to bed."						
	Review of anotho	r witness interview dated					
		etary supervisor on duty on					
		ndicated "Dietary Aide					
		sk me a question about if					
	' '	orce a resident to eat. She					
	stated that (name) told resident that she had					
	to eat 50% of her	food or she would have to					
	sit up in dining ro	om she was not going to be					
	a weight loss on h	ner watch. She told me I had					
	to report to (name	e) my supervisor."					
	Boylow of anotho	r witness statement dated					
		r witness statement dated m. supervisor/cook indicated					
		10 (name) came to me about					
		witnessed on Sunday					
		I me she had told (name)					
		after she witnessed it.					
		lanager was not here and					
		supervisor would not be here					
		told her we would not wait					
		ent to (name) the ADON on					
	1	reported everything to her,					
		ements and said she would					
	investigate the ma	atter.					
	Povious of the Con	enoneion Form indicated the					
		spension Form indicated the ded on 9/29/10 three days					
		Review of the Termination					
		10/4/10 the employee was					
	terminated from e						
		····					
	Interview with the	DON on 3/25/11 at 11:30					
	a.m., indicated sh	e was not employed at the					
		nt, and the Administrator at					
	that time was no	onger employed at the					

000236

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DITH	DDIC	00	COMPL	ETED
		155344	A. BUII B. WIN			03/28/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				HIGHWAY 20 EAST		
LIEE CAE	RE CENTER OF MI	CHICANICITY			GAN CITY, IN46360		
LIFE CAP	NE CENTER OF WIN	CHIGAN CHI		WIICITIC	SAN CITT, 11140300		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	further indicated the					
		l abuse was substantiated					
	by the facility.						
	2 4 27/b)						
	3.1-27(b)						
F0225	The facility must n	ot employ individuals who					
FU223	•	guilty of abusing, neglecting,					
		dents by a court of law; or					
	•	entered into the State					
		concerning abuse,					
		nent of residents or					
		of their property; and report					
		nas of actions by a court of					
	•	ployee, which would					
		for service as a nurse aide					
		iff to the State nurse aide					
	registry or licensin	g authorities.					
	The facility must e	nsure that all alleged					
		g mistreatment, neglect, or					
		njuries of unknown source					
		ion of resident property are					
		ely to the administrator of					
	•	other officials in accordance					
	with State law thro	ough established					
	procedures (includ	ling to the State survey and					
	certification agence	y).					
	•	ave evidence that all					
	-	are thoroughly investigated,					
		further potential abuse ation is in progress.					
	willie the investiga	ilion is in progress.					
	The results of all in	nvestigations must be					
	reported to the ad						
		entative and to other					
	•	ance with State law					
		tate survey and certification					
	,	orking days of the incident,					
		violation is verified					

000236

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DINC	00	COMPL	ETED
		155344	A. BUII B. WIN			03/28/20	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER						
	DE OENTED OF MI				HIGHWAY 20 EAST		
LIFE CAP	RE CENTER OF MI	CHIGAN CITY		MICHIC	GAN CITY, IN46360		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	appropriate correc	ctive action must be taken.					
SS=D	Based on recor	d review and	F0	225	F225		04/27/2011
	interviews, the facility failed to ensure				Resident B allegations of abuse was investigated. The LPN is no longer		
	every allegation	•			employed by the facility. Resident C		
	reported immed				allegation was investigated. Residen		
	•	nd every resident was			received counseling and psychiatrist		
		g the investigation for			services for her well being. Visitor informed he could not enter facility.	No I	
	•	•			actual harm noted to either resident.		
	_	ns of abuse reviewed			2 All residents have the potential to t	ре	
		ents reviewed for			affected by alleged deficient practice. Allegations of abuse will be		
	abuse in the sa	mple of 40. (Resident			reported to Indiana Department of		
	#B and #C)				Health and investigated immediately		
					ED/Designee. The facility policy on		
	Findings includ	e:			"Reporting Alleged Abuse" was amended to include "failure to repo	ort	
	3				alleged abuse immediately upon		
	1 Paviaw of th	ne Fax/Incident Report			occurrence or allegation will result	in	
		ndicated Resident #C			corrective action."		
					3.) Staff was in-serviced on 03/28/11 04/06/11 and 04/12/11 on types of	,	
		or (name) sat on the			abuse, reporting abuse, procedures	of	
		to talk to her on			and investigation of abuse by Nursin	g	
	Sunday evening	g. During this time she			Administration. Staff will be in-serviced monthly for 3 months a	nd l	
	said he kissed	her and patted her			quarterly thereafter on reporting		
	stomach area,	stating that she took			potential abuse immediately to		
	care of herself.	(Name) then stated			ED/Designee. ED/DON will audit 24		
		nis penis out of his			hour report daily M-F for potential abuse, incidents and accidents and	,	
	, , ,	his penis to her. The			review resident, family and staff	1	
		that the nurse (name)			complaints. The ED/DON is on call	24	
		, ,			hours a day. The weekend on call		
		saw the visitor sitting			manager will have her name posted on the staff assignment sheet for	¹	
		er bed and the nurse			immediate notification. All new state	ff	
	,	he visitor to leave the			will be informed of abuse policies i	n	
	building.				orientation and in ongoing		
					education. Allegations of abuse will be reported	to	
	A full body asse	essment was			Performance Improvement Committee		
	•	he resident, and there			monthly.		
		injuries. Urine was			The DON is responsible for ensuring		
		-			ongoing compliance. Compliance da 04/27/11.	ie l	
		he urinalysis was			5 <u>2</u> 7711.		
	positive for a U	TI (urinary tract	1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155344	B. WIN			03/28/2	011
NAME OF I	DDOWIDED OD CLIDDLIEI		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			802 US	HIGHWAY 20 EAST		
LIFE CAI	RE CENTER OF MI	CHIGAN CITY		MICHIG	GAN CITY, IN46360		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
	1 - 1	an antibiotic was					
	started.						
		on taken was both					
		interviewed, family					
		nysician notified. The					
		ed not to come into the					
		the investigation. A					
		as made and the police					
	_	arted. Staff was					
re-inserviced on abuse. An inservice							
	was also given	for after hours visitors.					
		leasures taken were					
		were immediately					
	•	to the other side of					
	the building. S						
		ind referrals were made					
		seling and a psychiatrist					
		C's well being. The					
		indicated they were					
		tantiate allegations,					
	· ·	investigation continues.					
		nitial and follow up					
	report.						
	Davience et cuit	and alakamenta buttler					
		ess statements by the					
		taking care of Resident					
		ndicated "A man came					
	1 '	e) (Resident #C's					
	1 '	e man was her son,					
		in he said 'Hi' then he					
	1 *	ne door and watched					
		lking to (name) mother.					
	A few days bef	ore this, one of the day					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2011 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION				SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUM	MBEK:	A. BUIL	DING	00		COMPL	
		155344		B. WINC				03/28/2	U11
NAME OF P	ROVIDER OR SUPPLIEF					DDRESS, CITY, STA	*		
						HIGHWAY 20 E			
	RE CENTER OF MI				MICHIG	AN CITY, IN463	bU		
(X4) ID		STATEMENT OF DEFICE			ID		LAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDI			PREFIX	CROSS-REFERENCE	E ACTION SHOULD BE ED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INI		-	TAG	DEFI	CIENCY)		DATE
		hat (Resident #	•						
		roommate's vis							
	came and tried to kiss her. So when I								
		ome in I kept ar	-						
		ing happened.							
	_	on, I told the nu							
		had told me and							
	•	eep an eye on t							
		get the call ligh							
	_	eir safely becaus							
	wasn't sure wh	at was going or	n or						
	even if that was	s the visitor that	t was						
	coming on day	s. When I got b	ack out						
	of the room tha	nt I was giving c	are to,						
	the nurse told r	me he had to as	sk the						
	man to leave b	ecause he tried	to kiss						
	(Resident #C).	Again I have n	ot seen						
		self. So I then							
	(Resident #C's) room to check	on her						
	and her roomm	nate. They acte	d fine						
	so I asked (Res	sident #C) if she	Э						
	,	lp into her night							
		but she had alre	•						
	changed into o		•						
	•	began to help h	er back						
		she said, 'That r							
	·	e.' and I said 'I k							
		nurse asked hin	_						
	•	thing else happ							
		ered 'No'. Afte							
		ne was fine, I be							
	•	n said, 'He tried	•						
		ked her what do							
	-	aid 'He tried to k	-						
		tell the nurse							
FORM CMS-2	567(02-99) Previous Version			 V9QC11	Facility I	D: 000236	If continuation sh	neet Pa	ge 16 of 91

Event ID: V9QC11 Facility ID:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		ì	X2) MULTIPL				(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	.i	A. BUILDING	(00		COMPL	
		155344	E	B. WING				03/28/2	U11
NAME OF I	PROVIDER OR SUPPLIEF					RESS, CITY, STAT	-		
						GHWAY 20 EA			
	RE CENTER OF MI			MIC	HIGAN	I CITY, IN4636	DU		
(X4) ID		STATEMENT OF DEFICIENCE		ID			AN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY		PREFIX	ζ (ACTION SHOULD BE O TO THE APPROPRIAT CIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORM		TAG	-	DEFIC	TENCY)		DATE
		ed to kiss (name) a	I .						
		he told him he ha							
	leave.' With me not seeing anything, I								
		isor what I heard. T	I .						
	he was the one that seen the action."								
		witness statement f							
	· •	that evening indica	I .						
		d have been aroun							
	l ·	September 19, 2010	1						
	Sometime duri	ng the beginning of	my						
	med pass a CN	NA came up to me a	and						
		#C) said that her							
	roommate's so	n wants to kiss her.							
	The aide then t	followed with 'but yo	ou						
	know sometime	es (Resident #C) ge	ets						
	confused.' I co	ontinued to pass a r	ned						
	or two then we	nt to their room. W	hen						
	I entered the ro	oom the resident's							
	privacy curtains	s were wide open a	ind						
	(Resident #C's) roommate introdu	ced						
	Ι,	lon't remember his							
	· ·	ent #C) was sitting	in						
	,	e dresser and this r	1						
	1	bout 4-5 feet away							
		f the bed with a nig	I .						
		nd facing the reside	1						
	•	of place because hi	1						
		eady in bed, and he	1						
		towards his mother							
		He was fully clothe							
		ee his penis expose	1						
	noticed a stron	•	· '						
		d him my name and	las I						
	1 -	I I told him he would	I .						
FORM CLES	ļ. !				71: 775		TC		
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete E	vent ID: V90	QC11 Fac	ility ID:	000236	If continuation sh	reet Par	ge 17 of 91

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE : COMPL		
		155344	A. BUI B. WIN	LDING IG		03/28/2	
NAME OF	PROVIDER OR SUPPLIER	 			ADDRESS, CITY, STATE, ZIP CODE	!	
					HIGHWAY 20 EAST		
	RE CENTER OF MI			<u> </u>	GAN CITY, IN46360		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	have to leave r	now. He put the					
	nightgown dow	n and left and I don't					
	recall him saying anything to me or						
	his mother on the way out. I looked						
	1	nd saw this guy walking toward main entrance.					
		dent #C) with her					
		continued my med					
	pass."	·					
		ther witness statement					
	1 -	nt Director of Nursing at					
	1	ated on 9/20/10 dent #C had reported to					
	1	ommate's son tried to					
		ght. She then reported					
	the allegation t	o the Director of					
	Nursing.						
	Review of the inve	estigation report indicated					
	the incident was r	not reported promptly to the					
	1	the Director of Nursing. Ursing was notified at 3:30					
	p.m. on 9/20/11.	aronig mao notinoa at 0.00					
	Interview with the	Director of Nursing on					
	1	o.m., indicated she was not					
	1	rsing at the time of the					
		o indicated the Administrator acility and was employed					
	elsewhere. The D	Director of Nursing indicated					
	-	buse was not reported					
		nistrator or the Director of he allegation of sexual					
	abuse investigate	_					
	2. The allegation	of verbal abuse for					
	1	reviewed on 3/25/11 at					

000236

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nnia	00	COMPI	LETED
		155344	A. BUI			03/28/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R					
	DE OENTED OF M	IOUIOAN OITY		1	HIGHWAY 20 EAST		
LIFE CAI	RE CENTER OF M	ICHIGAN CITY		MICHIC	GAN CITY, IN46360		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ACTION SHOULD BE	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	10:30 a.m. The i	ncident date was Sunday					
		description of the incident					
		was in the dining room when					
		talking in a loud voice, told					
	the resident to eat "because she was not						
	going to lose weig	ght on her watch."					
	The immediate as	ation taken was an					
		ction taken was an started, Executive Director					
		e suspended, physician					
	notified and family						
		, maunea.					
	The preventative measures taken were to						
	have Social Service follow up with the resident						
	and to re-educate	staff on the abuse policy.					
	Review of the witr	ness interview form dated					
	9/29/10 by the die	etary employee who					
		bal abuse indicated "I					
		a staff member telling a					
		at least has to eat 50% of					
		couldn't be moved out of					
		uld not go to bed. She also					
		gonna allow her to lose					
	_	tch. Then I left out of the					
		back to the kitchen. I came dining room. I heard the					
		he always does) and the					
		er (name) came into give					
		ked her to stop crying and if					
		aide will get mad at her and					
	not put her to bed						
	,						
	Review of anothe	r witness interview dated					
	9/29/10 by the die	etary supervisor on duty on					
		ndicated "Dietary Aide					
	l ' '	sk me a question about if					
		orce a resident to eat. She					
) told resident that she had					
		food or she would have to					
		om she was not going to be					
	a weight loss on h	ner watch. She told me I had					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155344		A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 03/28/2	ETED	
		100044	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/20/2	011
NAME OF I	PROVIDER OR SUPPLIER	2			HIGHWAY 20 EAST		
	RE CENTER OF MI				GAN CITY, IN46360		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG	to report to (name	LSC IDENTIFYING INFORMATION)	1	TAG	DLI ICILIAC I)		DATE
	to report to (name	in in supervisor.					
	9/30/10 by the a.m on Monday 9/27/1 some abuse she w 9/26/10. She told supervisor/p.m., a (Name) Dietary M (name) the p.m., s Monday either. It for them so we we that Monday and is she took her state investigate the marker was suspend after the incident. form indicated on terminated from elementary of the Sus LPN was suspend after the incident. form indicated on terminated from elementary of the staff indicated the LPN those statements immediately remocontinued to work. Interview with the a.m., indicated she time of the incider that time was no lefacility. The DON nor the Director of promptly notified of the staff indicated the lefacility. The DON nor the Director of promptly notified of the staff indicated she time was no lefacility. The DON nor the Director of promptly notified of the incider in the promptly notified of the promptly	spension Form indicated the ded on 9/29/10 three days Review of the Termination 10/4/10 the employee was imployment. witness forms and the tion form indicated they all 29/10 (three days after the opened and was witnessed). Ifing sheet for 9/26/10 that had allegedly made to the resident was not wed from the facility and					
	abuse. She furthe						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV OO COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	
		155344	B. WING		03/28/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
		CLUCAN CITY	I	S HIGHWAY 20 EAST	
LIFE CAP	RE CENTER OF MI		IVIICHI	GAN CITY, IN46360	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION) e shift. The DON further	TAG	DEFICIENCT)	DATE
		ation of verbal abuse was			
	substantiated by the				
	3.1-28(c)				
	3.1-28(d)				
F0226	The facility must d	levelop and implement			
1 0220	•	d procedures that prohibit			
		lect, and abuse of residents			
		ion of resident property.			
SS=D	Based on record	review and interview, the	F0226	F226 Resident B allegation of abuse was	04/27/2011
	facility failed to	follow their Abuse Policy		investigated and the LPN is no long	er
	related to prompt	tly reporting and		employed by the facility. Resident C	
	investigating alle	egations of sexual and		allegation of abuse was investigated and visitor informed he could not en	
		ensuring the residents		facility again. Resident received sen	
		om further abuse, for 2		counseling and psychiatric services	
	_	eviewed for abuse for 2		her well being. No actual harm note either resident.	1 10
	_	viewed for abuse in the		2. All residents have the potential to	I
		Resident #B and #C)		affected by the same deficient pract Allegations of abuse will be reported	I
	sumple of to. (It	resident "B and "C)		Indiana Department of Health and	
	Findings include			investigated immediately by	
	r manigs merade	•		ED/Designee. The facility policy or "Reporting Alleged Abuse" was	'
	Deview of the o	current and undated		amended to include "failure to rep	ort
				alleged abuse immediately upon occurrence or allegation will result	t in
		ed Abuse Policy,		corrective action."	
		Director of Nursing,		3.) Staff was in-serviced on 03/28/1	1,
	-	ersonnel, resident,		04/06/11 and 04/12/11 on types of abuse, reporting abuse, procedures	of
		sitor are encouraged to		and investigation of abuse by Nursir	I
		incidents of suspected		Administration. Staff will be	
		and/or neglect to		in-serviced monthly for 3 months a	ana
	_	ration. All alleged or		potential abuse immediately to	
	suspected viola			ED/Designee. DON/Designee will	
		abuse, neglect, injuries		audit 24 hour report daily M-F for potential abuse, incidents and	
	of unknown ori	gin (e.g. bruising and		accidents and review resident, fan	nily
				and staff complaints. The ED/DON	is

AND PLAN OF CORRECTION DENTIFICATION NUMBER: 155344 NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGAN CITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Skin tears) will be promptly reported to the administrator and/or director of A. BUILDING 00	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGAN CITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Skin tears) will be promptly reported to the administrator and/or director of STREET ADDRESS, CITY, STATE, ZIP CODE 802 US HIGHWAY 20 EAST MICHIGAN CITY, IN46360 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) On call 24 hours a day. The weekend on call manager will have her name posted on the staff assignment sheet	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGAN CITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Skin tears) will be promptly reported to the administrator and/or director of 802 US HIGHWAY 20 EAST MICHIGAN CITY, IN46360 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) On call 24 hours a day. The weekend on call manager will have her name posted on the staff assignment sheet	
LIFE CARE CENTER OF MICHIGAN CITY MICHIGAN CITY, IN46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Skin tears) will be promptly reported to the administrator and/or director of MICHIGAN CITY, IN46360 (X5) PREFIX CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) On call 24 hours a day. The weekend on call manager will have her name posted on the staff assignment sheet	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Skin tears) will be promptly reported to the administrator and/or director of ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) On call 24 hours a day. The weekend on call manager will have her name posted on the staff assignment sheet	
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Skin tears) will be promptly reported to the administrator and/or director of prefix PREFIX CEACH CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) On call 24 hours a day. The weekend on call manager will have her name posted on the staff assignment sheet	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Skin tears) will be promptly reported to the administrator and/or director of TAG CROSS-REFERENCED TO THE APPROPRIATE DATE On call 24 hours a day. The weekend on call manager will have her name posted on the staff assignment sheet	
skin tears) will be promptly reported to the administrator and/or director of on call 24 hours a day. The weekend on call manager will have her name posted on the staff assignment sheet	1
the administrator and/or director of on call manager will have her name posted on the staff assignment sheet	
the administrator and/or director of posted on the staff assignment sheet	
nursing. The person observing an for immediate notification. All new	
policies in orientation and in ongoing	
suspecting resident abuse will education.	
immediate such incidents to their Allegations of abuse will be reported to Performance Improvement Committee	
immediate supervisor and/or charge	
nurse. The supervisor and/or charge The DON is responsible for ensuring appropriate and the supervisor and	
nurse will illicit the following ongoing compliance. Compliance date is 04/27/11.	
information when the incident is	
reported: the name of the resident,	
the date and time of the incident,	
where the incident took place, the	
names of the persons committing or	
involved with the incident and the	
name of any witnesses. If the	
accused individual is an employee,	
they will be placed on suspension	
pending results of the investigation	
while the incident is being	
investigated.	
Review of the Fax/Incident Report	
dated 9/19/10 indicated Resident #C	
stated that visitor (name) sat on the	
side of her bed to talk to her on	
Sunday evening. During this time she	
said he kissed her and patted her	
stomach area, stating that she took	
care of herself. (Name) then stated	
(name) pulled his penis out of his	
pants exposing his penis to her. The	
resident stated that the nurse (name)	
walked in and saw the visitor sitting	
on the foot of her bed and the nurse	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU A. BUII		NSTRUCTION 00	(X3) DATE S COMPL	
		155344	B. WIN			03/28/2	011
	PROVIDER OR SUPPLIER		•	802 US	DDRESS, CITY, STATE, ZIP CODE HIGHWAY 20 EAST SAN CITY, IN46360	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	(name) asked t building.	he visitor to leave the					
	were no noted in collected, and to positive for a U	he resident, and there injuries. Urine was he urinalysis was					
	residents were notified, and physistor was asked building during police report was investigation stare-inserviced or	on taken was both interviewed, family sysician notified. The ed not to come into the the investigation. A as made and the police arted. Staff was a buse. An inservice for after hours visitors.					
	the roommates separated, one the building. So Resident #C, as to senior couns for Resident #C documentation unable to substand the police in This was the in report.	nd referrals were made seling and a psychiatrist C's well being. The indicated they were santiate allegations, nvestigation continues. itial and follow up					
	Review of witne	ess statements by the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155344	A. BUILDING	00	03/28/2011
		100011	B. WING	ADDRESS CITY STATE ZID CODE	00/20/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 20 EAST	
LIFE CAI	RE CENTER OF MI	CHIGAN CITY		GAN CITY, IN46360	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAG		,	IAG	DELICIENCE 1	DATE
		aking care of Resident dicated "A man came			
		e) (Resident #C's			
	· '	e man was her son,			
	'	in he said 'Hi' then he			
		e door and watched			
	l •	king to (name) mother.			
	A few days befo	ore this, one of the day			
	aides told me th	nat (Resident #C) said			
	that one of her	roommate's visitors			
	came and tried	to kiss her. So when I			
		ome in I kept an eye			
		ng happened. When a			
	_	on, I told the nurse			
		nad told me and that if			
	l -	eep an eye on them			
	I '	get the call light. It			
	· •	ir safely because I at was going on or			
		s the visitor that was			
		s. When I got back out			
		t I was giving care to,			
		ne he had to ask the			
	man to leave be	ecause he tried to kiss			
		Again I have not seen			
	anything for my	self. So I then went to			
	(Resident #C's)	room to check on her			
	and her roomm	ate. They acted fine			
	1	sident #C) if she			
	1	lp into her night-gown.			
		out she had already			
	changed into or				
		pegan to help her back			
		she said, 'That man			
	tried to kiss me	.' and I said 'I know			

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155344	A. BUI	LDING	00	COMPL 03/28/2	
		133344	B. WIN			03/20/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY		1	HIGHWAY 20 EAST SAN CITY, IN46360		
					1		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CV MUST BE REDCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		nurse asked him to					J.II.E
	_	thing else happen?'					
		ered 'No'. After					
		e was fine, I began to					
	_	n said, 'He tried to					
		ed her what do you					
	•	aid 'He tried to kiss me.'					
		tell the nurse and he					
		ed to kiss (name) and					
	_	he told him he had to					
	leave.' With me not seeing anything, I						
	told my supervisor what I heard. Then						
		that seen the action."					
	Review of the v	vitness statement from					
	the RN on duty	that evening indicated					
	"The time would	d have been around 7					
	p.m. Sunday, S	September 19, 2010.					
	Sometime durir	ng the beginning of my					
	med pass a CN	IA came up to me and					
	said (Resident	#C) said that her					
	roommate's soi	n wants to kiss her.					
	The aide then f	ollowed with 'but you					
		es (Resident #C) gets					
		ntinued to pass a med					
		nt to their room. When					
		om the resident's					
		s were wide open and					
	,) roommate introduced					
	·	on't remember his					
	,	ent #C) was sitting in					
	,	e dresser and this man					
	_	bout 4-5 feet away					
		the bed with a night					
	gown in his har	nd facing the resident.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344	(X2) MULTIPLE A. BUILDING B. WING	O0	(X3) DATE COMP - 03/28/2	LETED
	PROVIDER OR SUPPLIE		802 L	T ADDRESS, CITY, STATE, ZIP COI JS HIGHWAY 20 EAST	DE .	
LIFE CARE CENTER OF MICHIGAN CITY			MICH	IIGAN CITY, IN46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	mother was alr was not facing if to assist her. and I did not so noticed a stron (alcohol). I tolo precaution and have to leave r nightgown down recall him sayin his mother on to out the door ardown 100 hall I helped (Resion nightgown and pass." Review of another that time, indicated Resion her that her rook kiss her last night the allegation to Nursing. Review of the investment of the Director of Norm. on 9/20/11. Interview with the 3/25/11 at 12:30 p.m. on 9/20/11.	of place because his ready in bed, and he towards his mother as He was fully clothed, see his penis exposed. I g odor of etoh d him my name and as I told him he would now. He put the vn and left and I don't ng anything to me or the way out. I looked nd saw this guy walking toward main entrance. Hent #C) with her continued my med there witness statement at Director of Nursing at ated on 9/20/10 dent #C had reported to ommate's son tried to other Director of Nursing. In the Director of Nursing. In the Director of Nursing. In the Director of Nursing on other, indicated she was not resing at the time of the				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, pull paid	00	COMPLETED	
		155344	A. BUILDING B. WING		03/28/2011	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R	l	S HIGHWAY 20 EAST		
LIEE CAI		ICHICAN CITY	l l	GAN CITY, IN46360		
LIFE CA	E CARE CENTER OF MICHIGAN CITY		MICHIC	JAN CITT, 11146360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	incident. She als	o indicated the Administrator				
	had also left the f	acility and was employed				
	elsewhere. The I	Director of Nursing indicated				
	_	abuse was not reported				
	1	inistrator or the Director of				
		the allegation of sexual				
	abuse investigate	ed timely.				
		of verbal abuse for				
		reviewed on 3/25/11 at				
	10:30 a.m. The incident date was Sunday 9/26/10. The brief description of the incident was the resident was in the dining room when a nurse (named), talking in a loud voice, told the resident to eat "because she was not					
	going to lose weig	ght on her watch."				
	The immediate a	ction taken was an				
		started, Executive Director				
		e suspended, physician				
	notified and famil					
		y neuneu.				
	The preventative	measures taken were to				
		ice follow up with the resident				
		e staff on the abuse policy.				
		• •				
	Review of the wit	ness interview form dated				
		etary employee who				
	witnessed the ver	rbal abuse indicated "I				
		a staff member telling a				
		at least has to eat 50% of				
		couldn't be moved out of				
		ould not go to bed. She also				
		gonna allow her to lose				
		tch. Then I left out of the				
		back to the kitchen. I came				
	back to clean the dining room. I heard the					
		he always does) and the				
		er (name) came into give				
		ked her to stop crying and if				
		aide will get mad at her and				
	not put her to bed	1."	1			ı

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
ANDILAN	or correction	155344	A. BUII		00	03/28/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF F	PROVIDER OR SUPPLIER				HIGHWAY 20 EAST		
LIFE CARE CENTER OF MICHIGAN CITY			_		GAN CITY, IN46360		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFT ING INFORMATION)	+	IAG	Dia relativity		DATE
	Review of another 9/29/10 by the died Sunday 9/26/10 in (name) want to as someone could for stated that (name) to eat 50% of her fisit up in dining roo a weight loss on he to report to (name). Review of another 9/30/10 by the a.m on Monday 9/27/10 some abuse she with 9/26/10. She told supervisor/p.m., at (Name) Dietary Ma (name) the p.m., significantly many superior to them so we we that Monday and rishe took her stated investigate the many superior them so we were that Monday and rishe took her stated investigate the many superior them so we were that Monday and rishe took her stated investigate the many superior the Sus LPN was suspend after the incident. Form indicated on terminated from error review of all the with the date of 9/2 allegation had hap review of the staff indicated the LPN those statements to	witness interview dated tary supervisor on duty on dicated "Dietary Aide k me a question about if ree a resident to eat. She told resident that she had food or she would have to m she was not going to be er watch. She told me I had my supervisor." witness statement dated not supervisor/cook indicated to (name) came to me about witnessed on Sunday me she had told (name) fter she witnessed it. It anager was not here and supervisor would not be here old her we would not wait not to (name) the ADON on the eported everything to her, ments and said she would tter. pension Form indicated the eed on 9/29/10 three days Review of the Termination 10/4/10 the employee was					
	continued to work.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED			
AND PLAIN	OF CORRECTION	155344	A. BUILDING	00	03/28/2011	
			B. WING	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			HIGHWAY 20 EAST		
LIFE CARE CENTER OF MICHIGAN CITY			MICHIC	GAN CITY, IN46360		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE DATE	
F0247 SS=A	Interview with the a.m., indicated she time of the incident that time was no lot facility. The DON nor the Director of promptly notified of abuse. She further leave the facility in work the rest of the indicated the alleg substantiated by the facility is changed Based on record the facility failed room mate changing residents who make the changing residents who make the substantiated by the substantiated by the substantiated by the facility failed room mate changing residents who make the substantiated by the substantiated by the facility failed room mate changing residents who make the substantiated by the substantiated by the facility failed room mate changing residents who make the substantiated by the substant	DON on 3/25/11 at 11:30 e was not employed at the t, and the Administrator at onger employed at the indicated the Administrator Nursing at the time, were if the allegation of verbal or indicated the LPN did not inmediately and continued to e shift. The DON further ation of verbal abuse was ne facility. right to receive notice t's room or roommate in the ord review and interview, d to ensure notice of a inge was provided prior of rooms for 2 of 3 met the criteria for in the sample of 40. and #85)	F0247	F 247 Resident #42 was notified she was receiving a new roommate. Resident # 85 was also notified he vereceiving a new roommate. All residents have the potential to be affected by the same deficient pract All residents are aware of their new roommates. Residents who receive a new roommates. Residents who receive a new roommates. Residents who receive a new roommate Notification Form. Staff was in-service on 03/28/11, 04/06/11 and 04/12/11 transfer notifications. All New Roommate Notification Forms will be audited weekly by Social Services for notifications. Results of audit will be presented at monthly PI Committee Meeting for 6 months. Plan to be amended as indicated per monthly review by PI Committee. Threshold of compliance will be 95% before discontinuing auditions.	04/27/2011 was exice. mate exiced on exice.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLI	ETED
		155344	B. WIN			03/28/20	011
			В. WIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY		l	GAN CITY, IN46360		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG			DATE
	reviewed on 3/2 resident was acon 2/7/11. The documentation notified of a new 2/11 or 3/11 Nu	resident #42 was 25/11 at 8:30 a.m. The dmitted to the facility re was no of the resident being w room mate in the arses' Notes or the 2/11 I Service Progress			5.) The Social Services Director is responsible for ensuring ongoing compliance. Compliance date 04/27/11.		
	Social Service Sta were informed by	on 3/25/11 at 8:59 a.m., ff #1 indicated residents her verbally of a new room not document this in the					
	2. When interviewed on 3/21/11 at 10:27 a.m., Resident #85 indicated he had a new room mate. The resident indicated he was not given notice before receiving the new room mate.						
	3/25/11 at 8:40 a.m admitted to the fac readmitted on 1/4/ There was no doct thru 3/11 Nurses' N	11 after being hospitalized. umentation in the 12/10 Notes or the Social Service the resident being notified					
	Social Service Sta were informed by	on 3/25/11 at 8:59 a.m., ff #1 indicated residents her verbally of new room not document this in the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/G		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155344		DING		03/28/2	011
			B. WING	CTDFFT A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	8					
		CLUCANI CITY	I .		HIGHWAY 20 EAST		
LIFE CARE CENTER OF MICHIGAN CITY				MICHIG	SAN CITY, IN46360		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	•	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0250 SS=D	social services to highest practicable psychosocial well- Based on recor the facility failed services were p	provide medically-related attain or maintain the e physical, mental, and being of each resident. The review and interview, do to ensure social provided to maintain	F02	50	F250 Resident #6 has a Care Plan for depression.Resident #49 a behavior plan was developed. All residents exhibiting inappropriate		04/27/2011
	each resident's well-being relat service interver 1 of 3 residents psychoacitve managements who residents who residents who residents of contesting the statements of contesting residents who residents who residents who residents residen	highest practicable ted to lack of social nations for behaviors for serviewed for nedications of the 3 met the criteria for nedication use in the nd social service ollowing resident's depression for 1 of 10 met the criteria for nedications in the nedications i			All residents exhibiting inappropriate behaviors have the potential to be affected by the alleged deficient practice. The Social Service Director complete an audit of residents receive an antidepressant and ensure they have a behavior plan with intervention and behaviors exhibited by resident. Nursing staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 on facility policy/procedures for monitor and documenting resident behaviors and initiating a care plan by Nursing Administration. To ensure the allege practice does not recur social services and nursing will review the 24-hour report sheets daily m-f for any behavior issues to ensure behavior/depression care plans are written. Social Service/Designee we also review physician orders daily	will ving lave ats will ons	
	1. The record to reviewed on 3/2 resident was or facility on 10/15 readmitted to the The resident's of but were not line.	for Resident #6 was 23/11 at 8:04 a.m. The riginally admitted to the 5/00. The resident was ne facility on 6/1/09. diagnoses included, nited to, diabetes yalgia rheumatica, and			also review physician orders daily m-f for new antidepressant/antipsychotic order. The Social Service Director /Desginee will audit 5 resident behavior logs/physician orders weekly for 4 weeks and then monto ongoing to ensure care plan and behavior plans are in place. The results of these audits will be presented at monthly Performance Improvement meeting for 6 months. Plan to be amended as indicated by monthly reviews per the PI Committee. Threshold of compliance be 95% before discontinuing audits.	nly	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SI		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155344	B. WIN			03/28/20	711
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
1.155.041		OLUGAN OLTV		1	HIGHWAY 20 EAST		
LIFE CAR	LIFE CARE CENTER OF MICHIGAN CITY			MICHIC	GAN CITY, IN46360		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION	
TAG	Review of the 3/11 Physician Order		+	TAG	The Social Service Director is	DATE	
				responsible for ensuring ongoing			
	Statement indic			compliance.Compliance date 04/27/	11.		
	currently receiv						
		reat depression) 100					
		tablet by mouth one					
	time daily.	or or the					
	A Physician Notification form dated						
		ed the physician was					
		esident complaining of					
	l	depressed and stated					
		be better off dead.					
	The physician signed and returned						
	,	lotification form on					
		ders for the above					
	Wellbutrin med	ication to be initiated.					
	An ontry in the	0/10 Nurgos' notos					
	made on 9/19/1	9/10 Nurses' notes					
		esident stated that she					
		, complained of					
	'	d she slept all day and					
	· ·						
		sleep at night .The ated the resident said					
	1 7	be better off dead and					
	indicated the re	e died. The entry					
		d told the physician ed of the above. The					
		ated staff were to					
	Continue to Moi	iiloi liie resident.					
	The next entry	in the 9/10 Nurses'					
		le on 9/21/10 at 8:30					
	'	and the resident and					
	The next entry Notes was mad	in the 9/10 Nurses' le on 9/21/10 at 8:30 indicated the orders					
	were received a	and the resident and					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED				
		155344	B. WIN	G		03/28/20	11
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
LIFE CARE CENTER OF MICHIGAN CITY				1	HIGHWAY 20 EAST GAN CITY, IN46360		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	•	were notified. The					
	next entry in the	e Nurses' Notes was					
	made on 9/22/	10 at 10:30 a.m. This					
	entry indicated	the resident had a					
	restful night and	d had no signs or					
	symptoms of di	stress and staff were					
		w order for Wellbutrin					
	which was to be						
		entry also indicated					
	the staff were to continue to monitor						
	the resident.						
	Review of the r	esident's current care					
		there were no care					
	· •	monitoring for signs					
		of depression or mood					
	or the use of ar						
	medication.	ilidepressant					
	medication.						
	The Resident N	Mood Interview section					
	on the 12/7/10	MDS assessment					
	indicated the re	esident was coded as					
	indicating she h	nad symptoms of					
	_	epressed, or hopeless,					
		ing or staying asleep,					
		much, and feeling					
		little energy. The CAT					
		he MDS indicated the					
	resident triggered for psychotropic drug use and a care plan was to be						
	initiated.	care plan was to be					
	า แแนลเซน.						
	When interview	ed on 3/24/11 at 1:03					
		I Service Director					
	l ⁻	vas unaware of the					
	maioaica siic v	ras anaware or tile					

ll l		IDENTIFICATION NUMBER:			INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
(155344		ILDING		03/28/2	
		-	B. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY			GAN CITY, IN46360		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		e by the resident on					
		ocial Service Director					
		sident had always					
	been upbeat ar	nd pleasant and she					
	never observed	I the resident					
	displaying any	signs or symptoms of					
	depression or h	neard her make any					
	negative staten	nents before. The					
	Social Service	Director indicated she					
should have been informed of the statement made on 9/19/10 and she							
	would have act	ed upon and followed					
		dent and interventions					
	•	ne Social Service					
		ed a plan of care for					
		of depression and the					
		depressant medication					
		should have been					
	initiated at that						
SS=D		for Resident #49 was			F250		04/27/2011
		23/11 at 9:23 a.m. The			Resident #6 has a Care Plan for		01/2//2011
		agnoses that included,			depression.Resident #49 a behavior plan was developed.		
		nited to, dementing			All residents exhibiting inappropriate		
		ociated behavioral			behaviors have the potential to be affected by the alleged deficient		
		ture of left hip and			practice. The Social Service Director	will	
	dementia.	ture or left hip and			complete an audit of residents receiv		
	dementia.				an antidepressant and ensure they have Plans written and those resider		
	The Admission	MDS (Minimum Data			who exhibit inappropriate behaviors	will	
		nt with the reference			have a behavior plan with intervention and behaviors exhibited by resident.		
	•	I was reviewed. It			Nursing staff was in-serviced on		
		esident understood and			03/28/11, 04/06/11 and 04/12/11 on		
					facility policy/procedures for monitori and documenting resident behaviors	•	
	understands, th	•			and initiating a care plan by Nursing		
		ental Status) score was			Administration. To ensure the allege	d	
	_	derate cognitive			practice does not recur social services and nursing will review th	e	
	impairment.				.		
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	V9QC11	Facility 1	ID: 000236 If continuation sl	neet Pa	ge 34 of 91

Event ID: V9QC11 Facility ID:

Page 34 of 91

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			JRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ΓED	
		155344	B. WIN			03/28/20 ⁻	11
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			HIGHWAY 20 EAST		
LIFE CAI	RE CENTER OF MI	CHIGAN CITY		1	GAN CITY, IN46360		
					5AN 611 1, 11440500		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re '	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG			DATE
					24-hour report sheets daily m-f for any behavior issues to ensure		
	The resident w	as admitted to the			behavior/depression care plans are		
	facility on 1/14/	/11 with physician's			written. Social Service/Designee w		
	orders for Zypr	exa (an antipsychotic			also review physician orders daily		
	medication) 2.5	5 mg at bedtime.			m-f for new antidepressant/antipsychotic order	rs	
	'	J			The Social Service Director		
	The "Nurse's N	lotes" were reviewed.			/Desginee will audit 5 resident		
		entry dated 2/7/11 at			behavior logs/physician orders weekly for 4 weeks and then month	,,,	
		-			ongoing to ensure care plan and	···y	
	9:00 p.m. that indicated, " res (resident) conts (continues) to be				behavior plans are in place.		
					The results of these audits will be presented at monthly Performance		
	highly combative, spit meds (medications) out x 2, pinched CNA et				Improvement meeting for 6 months.		
					Plan to be amended as indicated by		
	1 ' '	NA and nurse when			monthly reviews per the PI		
	attempting to p	rovide care, res does			Committee. Threshold of compliance be 95% before discontinuing audits.	WIII	
	not redirect	" The next entry dated			The Social Service Director is		
	2/8/11 at 12:50	a.m. indicated, "			responsible for ensuring ongoing		
	Writer informed	d resident of getting VS			compliance.Compliance date 04/27/	11.	
		esident seemed OK at					
		came angry at writer.					
		n to swing both hands					
	_	er et stated, 'Get the h-					
		Writer was able to get					
		•					
	VS after a shor	t periou					
	A b	udanisa abtat					
		rder was obtained on					
	2/8/11. The phy						
		yprexa was to be					
	increased to 5	mg at bedtime.					
	The form titled	"MDS 3.0 Social					
	Service Progre	ss Note: Resident					
	Interview," dat						
	· ·	he Social Service					
		eviewed. The note					
	_Г пішсак с и, дур	rexa increased to 5 mg					

000236

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155344		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED 03/28/2011			ETED		
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	(802 US	HIGHWAY 20 EAST		
LIFE CARE CENTER OF MICHIGAN CITY				MICHIG	GAN CITY, IN46360		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG			COMPLETION DATE
IAG		esident had some		IAG			DATE
	combative behavior during this reference period - care plan to be						
	written. "						
	The policy title	•					
	Non-compliant Behaviors"						
	•	n 8/3/2004 was					
	provided by the Social Service Director on 3/24/11 at 9:45 a.m. She indicated the policy was current. The policy indicated that, "Upon review of						
		ssessing causes of the					
		tom, a behavior plan					
	will be develop	ed. The behavior plan					
	will specify the	problem, behavior					
		, and individualized					
		es and response					
	interventions."						
	The "Rehavior	Book" was provided on					
		Social Service Director.					
	•	pehavior plan in the					
		for Resident #49.					
	Interview with t	the Social Service					
		4/11 at 9:10 a.m.					
		was no behavior plan					
		t's combative behavior					
	_	are. She indicated the					
	•	was to be documented					
	on the form title	cord" and was to be in					
	_	Book" for the staff to					
		ocial Service Director					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	ETED
		155344	B. WING			03/28/2	011
	PROVIDER OR SUPPLIEF			802 US	DDRESS, CITY, STATE, ZIP CODE HIGHWAY 20 EAST AN CITY, IN46360		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	<u> </u>	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PR	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0253 SS=C	indicated the b sheet was to be specific behavior interventions to staff to reduce behaviors. Interview with ton 3/24/11 at 9 there was no be Resident #49. 3.1-34(a) The facility must promote a sanitary, orderly Based on obsetthe facility faile and comfortable to scratched are cabinets and fubaseboard and bowls, and close not shut in 4 of the Homeward lounge area and rooms on the 2 on the 300 Unit 400 unit and in 500 unit. This	ehavior monitoring e used to identify ors and to provide be used by direct care the resident's the Director of Nursing :45 a.m. indicated ehavior plan for provide housekeeping and rices necessary to maintain and comfortable interior. ervation and interview, d to maintain a clean e environment related and marred doors, arniture, dirt along the affloor tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set doors that would afford tile, rust in toilet set	F025		F253 On the Homeward Bound Unit: The to (2) dressers in room 105 have been replaced. The chipped wood door have been fixed. The bathroom door in room 108 has been painted. The chipped marred door in room 113 has been fixed. The cove base in room 114 have been repaired and bathroom door have been painted. The shower room has been painted underneath the sink. Thus (2) table bases have been refinished and the end table remove On the 200 Unit: Dirt along baseboard of the floor tile in the bathroom of room 214 was cleaned. On the 300 Unit: The wall in room 311 was fixed. Dirt along baseboard of bathroom and scuffmat were cleaned. Baseboard in room 3 was fixed and metal strip on bathroom	as oom and as as he d. rds oom The g urks	04/27/2011
	facility. (Room 201, 214, 310,	ents who resided in the s 105, 108, 113, 114, 311, 406, 407, 408, 503, 505, 510 and			floor was removed. Women's shower om discolored grout around toilet we cleaned. Men's shower room discolor grout underneath sink was cleaned. six cabinet doors under sink in Small Dining Room were refinished. On the	was ored The I	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIM DDIG	00	COMPLETED
		155344	A. BUILDING		03/28/2011
			B. WING	EET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹			
		CLUCAN CITY		US HIGHWAY 20 EAST	
LIFE CAI	RE CENTER OF MI	CHIGAN CITY	I WIIC	HIGAN CITY, IN46360	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	I CROSS-REFERENCED TO THE APPROPR	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	514)			400 Unit: The wall in room 406 wa	
				fixed. The rust stains were remove from the toilet. The food spillage o	
	Findings includ	le·		of room 407 was cleaned. The stic	
	i manigo molado.			floor was scrubbed. The rust stain:	s in
	1 The followin	ng was observed on the		toilet were removed. The bathroon	1 floor
		_		was cleaned of dirt accumulation. Corners by door of resident's room	n and
		und Unit on 3/21 and		bathroom have been cleaned. The	
	3/22/11:			bathroom floor of room 408 was	
				scrubbed. The rust stains were rer from the toilet. The corners by resi	
	a. On 3/22/11	at 8:14 a.m., the		room door and bathroom door hav	
	bottom four inc	hes of 2 of 2 dressers		been cleaned. The wall at the foot	
	located in room	n 105 were scratched		bed 2 in room 409 has been fixed.	
	and marred T	he inside of the room		rust stains were removed from the The wall in room 410 has been	tollet.
		a section of chipped		repaired. The dirt has been cleane	ed in
		sured 5 inches by 1		corners of bathroom floor and deb	
		•		removed. The closet door has bee	
		dents resided in this		fixed. On the <u>500Unit</u> : The dirt has cleaned along baseboard in room	
	room.			The floor in room 503 has been	
				scrubbed and the dirt cleaned alor	· I
	b. The bottom	of the bathroom door		baseboard. The closet doorknob h been tightened. The floor mat in ro	
	in room 108 wa	as observed to be		505-2 has been replaced. The bat	•
	scratched and	marred in a 12 inch		floor in room 510 was scrubbed. T	
	section on 3/22	2/11 at 8:21 a.m. Two		bathroom door has been painted. floor mat in room 514-1 has been	The
		ed in this room.		replaced. The bathroom floor has	been
	Tesidents resid	ca in this room.		scrubbed.	
	a The deem to	112a		The Environmental Services Direc	tor
	c. The door to			and the Maintenance Director completed an audit of all resident	
		chipped and marred		rooms, dining rooms, activity areas	s,
	on the inside ir	a 3 inch by 1 inch		shower rooms and all common are	
	section on 3/22	2/11 at 8:50 a.m. Two		the facility to identify concerns rela	
	residents resid	ed in this room.		marred, chipped and scratched do walls, furniture and cabinets. An a	•
				was also done to address the adhe	
	d. On 3/21/11	at 2:40 p.m., the cove		dirt in corners and along baseboar	•
		erved to be broken near		discolored grout in shower rooms, broken cove base, dull and scuffed	
		loor in room 114. The		floors, rust stains in toilet bowels,	
				doors and loose knobs, floor mats	
		throom door was also		facility. Any area identified as a res	
		marred. Two residents		the audit were cleaned, repaired o	r
	resided in this	room.		replaced.	

PREFIX (FACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET	l ´		(X2) MULTIPI	LE CON	NSTRUCTION	(X3) DATE S	SURVEY		
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGAN CITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET	AND PLAN	LAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	ETED	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGAN CITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (FACH DEFICIENCY MUST BE PERCEDED BY FULL) STREET ADDRESS, CITY, STATE, ZIP CODE 802 US HIGHWAY 20 EAST MICHIGAN CITY, IN46360 (X5) PROVIDERS PLAN OF CORRECTION (FACH DEFICIENCY MUST BE PERCEDED BY FULL) PREFIX (FACH CORRECTIVE ACTION SHOULD BE COMPLET			155344				03/28/2	011	
LIFE CARE CENTER OF MICHIGAN CITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (FACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET				_	EET AI	DDRESS, CITY, STATE, ZIP CODE			
LIFE CARE CENTER OF MICHIGAN CITY MICHIGAN CITY, IN46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (FACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET	NAME OF I	OF PROVIDER OR SUPPLIEF	t	802	802 US HIGHWAY 20 EAST				
PROVIDERS PLAN OF CORRECTION (FACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY ACTION SHOULD BE COMPLETE (EACH DEFICIENCY ACTION SHOULD BE COMPLETE (EACH DEFICE ACTION SHOULD BE COMPLET	LIFE CAI			МІС	CHIG	AN CITY, IN46360			
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE		l l	STATEMENT OF DEFICIENCIES	1		PROVIDER'S PLAN OF CORRECTION		(X5)	
CROSS-REFERENCED TO THE APPROPRIATE	PREFIX	X (EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFI	IX	CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DATE	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	j			DATE	
2. The following was observed on the 200 unit on 3/21 and 3/22/11: a. On 3/21/11 at 3:49 p.m., adhered dirt was observed along the base board throughout room 201. One resident resided in this room. b. On 3/22/11 at 8:29 a.m., adhered dirt was observed along the base board of the floor tile in the bathroom of room 214. One resident resided in this room. 3. The following was observed on the 300 unit on 3/21/11: a. At 10:51 a.m., the walls in room 311 were observed along the floor tile. One resident resided in this room. b. At 2:27 p.m., a small section of base board was peeling away from the wall by the closet in room 310. A piece of metal stripping was observed on the bathroom floor. Two residents resided instrained in this room.	IAU	2. The followin 200 unit on 3/2 a. On 3/21/11 dirt was observe board througher 201. One reside room. b. On 3/22/11 dirt was observe board of the floor of room 214. One this room. 3. The followin 300 unit on 3/2 a. At 10:51 a.r. 311 were observe and marred. A and dirt was observe also observ	at 3:49 p.m., adhered red along the base out room dent resided in this at 8:29 a.m., adhered red along the base or tile in the bathroom one resident resided in ag was observed on the 1/11: and 3/22/11: at 3:49 p.m., adhered red along the base or tile in this at 8:29 a.m., adhered red along the base or tile in the bathroom one resident resided in ag was observed on the 1/11: and the walls in room reved to be scratched in accumulation of dust reserved along the base of athroom. Scuff marks reved along the floor ent resided in this and a small section of the speeling away from closet in room 310. A stripping was observed in floor. Two residents			The housekeeping and maintenance staff was in-serviced on proper clear procedures, repairs and painting on 03/31/11, 04/06/11 and 04/07/11. An environmental audit of every residen room, dining rooms, activity areas, shower rooms and all common areas the facility will be completed by the Environmental Services Director and the Maintenance Director weekly for days. After the 60 days, audits will be completed for random areas of the facility weekly. The results of the audits will be presented to the Performance Improvement Meetings on a monthly basis for 6 months. Plan to be amendas indicated by monthly review per PC Committee. Threshold of compliance will be 95% before audits are discontinued. The Environmental Services Director and the Maintenance Director will be responsible for ensuring compliance.	t s of l 60 e	DAIE	

000236

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344		(X2) MI A. BUII B. WIN	LDING	nstruction 00	(X3) DATE S COMPL 03/28/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	<u> </u>		STREET A	DDRESS, CITY, STATE, ZIP CODE		
LIFE CAI	RE CENTER OF MI	CHIGAN CITY			HIGHWAY 20 EAST SAN CITY, IN46360		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION
TAG		g was observed on the 1 and 3/22/11:		TAG	DEFICIENC!)		DATE
	in room 406 we marred. Rust sobserved in the residents residents residents. On 3/22/11 an accumulation the floor by the 407. The floor stains were obtained the bathrough finish and an analy dirt. A larged dirt was observed to cated by the room and the bathrough floor the floor that is the floor that	at 8:35 a.m., the walls ere scratched and stains were also e toilet bowl. Two ed in this room. at 8:37 a.m., there was en of food spillage on garbage can in room was also sticky. Rust served in the toilet bowl om floor had a dull occumulation of dust e amount of adhered red in the corners door to the residents' eathroom door. Two ed in this room.					
	was observed dirty on 3/22/11 stains were als bowl. Adhered the corners loc room and the b	om floor in room 408 to be discolored and I at 8:32 a.m. Rust o observed in the toilet dirt was observed in ated by the door to the eathroom door. Two ed in this room.					
	the foot of bed scratched and	at 2:52 p.m., the wall at 2 in room 409 was marred. Rust stains erved in the toilet bowl.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155344		(X2) MULTIPLE (A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/28/2011	
	PROVIDER OR SUPPLIER		STREE 802 U	T ADDRESS, CITY, STATE, ZIP COD JS HIGHWAY 20 EAST IIGAN CITY, IN46360	E
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	ILD BE COMPLETION
		resided in this room.			
	observed to be on 3/21/11 at 2 accumulation of the bathroom fl accumulation of corners of the f would also not	scratched and marred :46 p.m. There was an f dust and debris on oor as well as an f adhered dirt in the loor. The closet door shut all of the way.			
	5. The followin 500 unit on 3/2	g was observed on the 2/11:			
	the base board	t was observed along in room 502 at 9:16 lent resided in this			
	503 had a dull an accumulation the base board	, the tile floor in room finish. There was also n of adhered dirt along . The door knob on was also loose.			
	in room 505 at	at located next to bed 2 9:06 a.m., was stained in sections			
	room 510 was finish. The insi	, the bathroom floor in observed to have a dull de of the bathroom rved to be scratched			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155344	B. WING			03/28/2	011
		1	<i>p.</i> ,, , , ,		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	R			HIGHWAY 20 EAST		
LIFE CA	RE CENTER OF M	ICHIGAN CITY			GAN CITY, IN46360		
					, , , , , , , , , , , , , , , , , , , ,		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	and marred ald	ong the middle.					
	e. The floor m	nat located next to bed					
	1 in room 514	at 8:45 a.m., was					
	observed to be stained and dirty. The						
		also had a dull finish					
	and was in nee	ed of cleaning.					
		Housekeeping and					
		ervisors on 3/25/11 at 11:30					
	a.m., indicated the above areas were in need						
	of cleaning and repair.						
	6. During the Environmental Tour on 3/25/11						
	_	h the Housekeeping and					
		ervisors, the following was					
	observed:	or receive, and remaining made					
	a. The Homeware	d Bound shower room was					
	observed to have	chipped areas of paint					
	underneath the si	nk.					
	l						
		dining room tables located					
		Bound lounge/dining area					
		scratched. The finish on the					
	•	le in the lounge area where					
	scratched.	placed, was also marred and					
	Joratoneu.						
	c. The arout in th	e floor tile in the 300 unit					
		room was discolored					
	around the toilet.						
	_	e floor tile located					
		nk in the Men's shower room					
	on the 300 unit wa	as discolored.					
	<u> </u>						
		ocated under the sink in the					
		m were scratched and					
	marred.						

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	E CONSTRUCTION 00	ľ í	(X3) DATE SURVEY COMPLETED	
ANDILAN	or correction	155344	A. BUILDING		- 03/28/2		
			B. WING	EET ADDRESS, CITY, STATE, ZIP CO			
NAME OF P	ROVIDER OR SUPPLIER			US HIGHWAY 20 EAST	322		
	RE CENTER OF MI	CHIGAN CITY		CHIGAN CITY, IN46360			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE		(X5)	
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI. TAG	CROSS-REFERENCED TO THE A		COMPLETION DATE	
IAG	REGULATORT OR	ESC IDENTIFY TING INFORMATION)	IAG			DAIL	
	Maintenance Supe	Housekeeping and ervisors at the time, e areas were in need of pair.					
	3.1-19(f)						
F0272	periodically a com	onduct initially and prehensive, accurate, oducible assessment of nctional capacity.					
	A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:						
	Customary routine Cognitive patterns Communication;						
	Vision; Mood and behavion Psychosocial well-						
	Continence;	ng and structural problems;					
	Dental and nutrition Skin conditions; Activity pursuit;						
	Medications; Special treatments						
	Discharge potential Documentation of regarding the additional control of the cont	summary information					
	performed through protocols; and Documentation of	n the resident assessment					
	assessment.	pa. aaipaaari iii					
SS=E		rvation, record review he facility failed to	F0272	F272 Resident #3 Quarterly corrected. Resident #4		04/27/2011	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLE	TED	
		155344	B. WIN			03/28/20	11	
		ll	P. (12		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIEF	8		1	HIGHWAY 20 EAST			
LIFF CA	RE CENTER OF MI	CHIGAN CITY		MICHIGAN CITY, IN46360				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	COMPLETION	
TAG	+	LSC IDENTIFYING INFORMATION)	-	TAG		. 	DATE	
		imum Data Set (MDS)			assessment form was updated]		
	1 '	e assessment was			and significant change completed.Resident #95 MDS	,		
	coded accurate	ely related to nutrition			was corrected.Resident #102			
	and weight los	s as well as oral cavity			MDS was corrected.Resident	·		
	status for 5 of 2	25 residents whose			#144 MDS was corrected.			
	MDS assessm	ents were reviewed in			All residents have the potentia	ıl to		
		(Residents #3, #49,			be affected by the same defici	ent		
	#95, #102, and	•			practice. The Dietary Manager			
	1 100, 11 102, and	, ,, , , , , , , , , , , , , , , , , , ,			use the most recent weight for			
	Eindings inclus	lo:			reference period when comple			
	Findings includ	le.			MDS. The MDS coordinator w audit residents with significant			
	l <u> </u>				weight losses for an accurate	·		
	The record for Resident #3 was				MDS. The MDS Coordinator	will		
		23/11 at 8:40 a.m. The			discuss any discrepancies w			
	resident's Qua	rterly MDS Assessment			Dietary Manager before the			
	dated 2/4/11, ir	ndicated the resident			completion of the MDS. All o	ral		
	had not had a	weight loss of 5% or			cavity assessments will be			
	more in the las	t month.			updated by nursing and			
					compared to current MDS to			
	The monthly w	eight sheet indicated			ensure accuracy by the MDS			
	1	eighed 163.8 pounds			Coordinator.			
	1	150.4 pounds on			The significant weight losses v			
		130.4 pourius on			be audited monthly for accurate MDS by DON/Designee. Dieta			
	2/1/11.				Manager/Registered Dietician	· 1		
					was in-serviced on 04/12/11 o			
	1	ogress Note completed			using most recent weight for			
		red Dietitian (RD) on			MDS.			
	2/26/11, indica	ted "February weight			Results of audits will be			
	150.4, down 8.	1% in 1 month,			presented at monthly PI			
	significant weigh	ght loss, physician and			Committee Meeting for 6 month			
	family notificati	on was requested."			Plan to be amended as indicate per monthly review per Pl	tea		
		•			Committee. Threshold of			
	Interview with I	MDS Coordinator #1 on			compliance will be 95% before	,		
		a.m., indicated she			discontinuing audits.	_		
	1	n the resident's weight			The DON/MDS Coordinator is			
	1	•			responsible for ensuring ongoi			
	1	e Quarterly MDS was			compliance.Compliance date			
	coded accurate	ely. Further interview at						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155344	B. WING		03/28/2011
				T ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	L		JS HIGHWAY 20 EAST	
	RE CENTER OF MI	CHIGAN CITY		IIGAN CITY, IN46360	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
SS=E	MDS was code to the resident's the assessmen indicated the D completes that prints up her was sometimes after reference period. The record for reviewed on 3/3 Review of the inset (MDS) assess with an assess 2/10/11 indicate recorded weight Weight loss five the past month the assessmen Review of the coin the resident's indicated the repounds on 2/3/admitted to the another weight indicated the repounds (an eigsix days). Interview with M 3/24/11 at 8:40 recorded weight	er the assessment od. or Resident #144 was 23/11 at 1:10 p.m. nitial Minimum Data essment dated 2/16/11, ment reference date of ed the resident of was 100 pounds. Expercent or greater in was not indicated on out.		F272 Resident #3 Quarterly MDS was corrected. Resident #49 oral assessment form was update and significant change completed.Resident #95 MDS was corrected.Resident #102 MDS was corrected.Resident #102 MDS was corrected.Resident #144 MDS was corrected. All residents have the potentiable affected by the same deficipractice. The Dietary Manage use the most recent weight for reference period when completed to with significant weight losses for an accurate MDS. The MDS coordinator waudit residents with significant weight losses for an accurate MDS. The MDS Coordinator discuss any discrepancies will be updated by nursing and compared to current MDS to ensure accuracy by the MDS Coordinator. The significant weight losses be audited monthly for accurate MDS by DON/Designee. Dietary MDS by DON/Designee. Dietary MDS by DON/Designee.	d S al to ient r will r eting vill t will vith oral S will tte ary
	closest to the a	ssessment reference		Manager/Registered Dieticiar	·

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155344	A. BUI	LDING	00	03/28/2	
		100044	B. WIN			03/26/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
LIEE CAI	RE CENTER OF MI	CHIGANI CITY		1	HIGHWAY 20 EAST GAN CITY, IN46360		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION DATE
1710	date), which the		+	mo	was in-serviced on 04/12/11 o	n	DATE
	l ''	ght loss of greater than			using most recent weight for		
	five percent in t	•			MDS.		
	Further intervie	•			Results of audits will be		
	Coordinator #1				presented at monthly PI Committee Meeting for 6 month	he	
		ht and weight loss was			Plan to be amended as indicated		
	inaccurately co	•			per monthly review per PI		
	accaratory co	~~.			Committee. Threshold of		
	3. The record	for Resident #102 was			compliance will be 95% before discontinuing audits.	•	
		24/11 at 8:30 a.m. The			The DON/MDS Coordinator is		
		ed 2/2/11 with the			responsible for ensuring ongoi	ng	
		ference date of 1/29/11			compliance.Compliance date		
		esident weighed 185			04/27/11.		
		e resident did not have					
	•	reater than 5 percent in					
	the past month	•					
	Review of the	resident's weight					
		d the resident weighed					
	195 pounds on	1/20/11 at the time of					
	admission and	then weighed 185					
	pounds on 1/25	5/11. The resident had					
	a 10 pound wei	ight loss in five days					
	which is greate	r than five percent in					
	the past month						
	Interview with N	MDS Coordinator #1 on					
	3/24/11 at 12:2	5 p.m. indicated the					
	•	d on MDS was correct,					
		nt loss greater than five					
	l '	have been indicated					
	on the initial MI						
SS=E		or Resident # 95 was			F272	00	04/27/2011
		23/11 11:07 a.m. The			Resident #3 Quarterly MDS was corrected. Resident #49 oral	as	
	resident has dia	agnoses that included,			Concoled. Nesident #43 Old		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155344 03/28/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 802 US HIGHWAY 20 EAST LIFE CARE CENTER OF MICHIGAN CITY MICHIGAN CITY, IN46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE but were not limited to, squamous cell assessment form was updated and significant change cancer of the neck, valvular heart completed. Resident #95 MDS disease, depression with anxiety, and was corrected.Resident #102 chronic kidney disease on dialysis. MDS was corrected.Resident #144 MDS was corrected. The Admission MDS (Minimum Data All residents have the potential to be affected by the same deficient Set) assessment with the reference practice. The Dietary Manager will date of 2/14/11 was reviewed. The use the most recent weight for weight listed on the MDS was 220 reference period when completing pounds. MDS. The MDS coordinator will audit residents with significant weight losses for an accurate Review of the February 2011 MAR MDS. The MDS Coordinator will (Medication Administration Record) discuss any discrepancies with indicated the resident had daily Dietary Manager before the weights recorded. The resident's completion of the MDS. All oral weight on 2/14/11 was documented cavity assessments will be updated by nursing and as 199 pounds. compared to current MDS to ensure accuracy by the MDS Interview with the MDS Coordinator Coordinator. #1 on 3/14/11 at 2:27 p.m. indicated The significant weight losses will the weight recorded on the MDS was be audited monthly for accurate inaccurate. She indicated the weight MDS by DON/Designee. Dietary Manager/Registered Dietician should have been recorded as 199 was in-serviced on 04/12/11 on pounds and not 220 pounds. using most recent weight for MDS. 5. Resident #49 was observed on 3/23/11 Results of audits will be presented at monthly PI at 4:45 p.m. in bed. Observation of the Committee Meeting for 6 months. resident's oral cavity indicated the resident Plan to be amended as indicated had no natural teeth on top and had some per monthly review per PI natural teeth on the bottom. Two of the teeth were noted to be discolored and one tooth Committee. Threshold of compliance will be 95% before was broken discontinuing audits. The DON/MDS Coordinator is The record for Resident #49 was reviewed responsible for ensuring ongoing on 3/3/11 at 9:23 a.m. The resident had compliance.Compliance date diagnoses that included, but were not limited

Facility ID:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344			(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 03/28/2	ETED
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
LIFE CA	RE CENTER OF MI	CHIGAN CITY			HIGHWAY 20 EAST GAN CITY, IN46360		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
mo	to, fracture of left l	nip, dementing illness with oral symptoms, pressure		710	04/27/11.		DIIIE
	assessment with t was reviewed. The	DS (Minimum Data Set) he reference date of 1/21/11 e MDS indicated the ral/dental problems.					
		ral Assessment Form" and not indicate that the resident eeth.					
	resident's private or resident has no na has an upper dent	11 at 4:45 p.m. with the care giver indicated the atural teeth on the top, she ture but she does not like to indicated the resident has a see bottom.					
	3/23/11 indicated	ADON at 3:45 p.m. on she was not aware of any en she completed the MDS.					
	MDS Coordinator	on 3/25/11 at 10:11 a.m., #1 indicated the Admission sessment Form" dated curate.					
	3.1-31(c)(5) 3.1-31(c)(9)						
F0279		e the results of the velop, review and revise the hensive plan of care.					
	care plan for each measurable object meet a resident's	develop a comprehensive i resident that includes tives and timetables to medical, nursing, and osocial needs that are					

000236

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155344 03/28/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 802 US HIGHWAY 20 EAST LIFE CARE CENTER OF MICHIGAN CITY MICHIGAN CITY, IN46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical. mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b) (4). SS=D F279 Based on record review and interview, F0279 04/27/2011 Resident #6 has a Care Plan for the facility failed to develop a care depression. plan related to statements made by All residents on antidepressants the resident during an resident mood have the potential to be affected interview conducted by staff during by the same deficient practice. An audit of all residents on the MDS (Minimum Data Set) antidepressants was conducted. assessment reference period of Residents on antidepressants will 11/23/10 for 1 of 10 residents have a Care Plan monitoring for reviewed for unnecessary signs/symptoms of depression. medications in the sample of 40. Staff in-serviced on 03/28/11, 04/06/11 and 04/12/11 on (Resident #6) initiating Care Plans for residents in depression by Nursing Findings include: Administration. 20% of residents on antidepressants will be audited The record for Resident #6 was weekly for antidepressant Care Plans. reviewed on 3/23/11 at 8:04 a.m. The Results of these audits will be resident was originally admitted to the presented in monthly PI facility on 10/15/00. The resident was Committee for 6 months. Plan to readmitted to the facility on 6/1/09. be amended as indicated per The resident's diagnoses included. monthly review per PI Committee. Threshold of compliance is 95% but were not limited to, diabetes before discontinuing audits. mellitus, polymyalgia rheumatica, and Social Services Director is high blood pressure. responsible for ensuring ongoing compliance. Compliance date 04/27/11. Review of the resident's current care

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

V9QC11

Facility ID:

000236

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155344		A. BUILD		00	(X3) DATE S COMPL 03/28/2	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 802 US HIGHWAY 20 EAST MICHIGAN CITY, IN46360					
	RE CENTER OF MI SUMMARY S (EACH DEFICIEN REGULATORY OR plans indicated plans related to and symptoms or the use of ar medication. The Resident N on the 12/7/10 indicated the re indicating she h feeling depress trouble falling of sleeping too mo or having little of worksheet for ti resident trigger drug use and a initiated. Review of the 3 Statement indic currently receiv medication to the	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) there were no care monitoring for signs of depression or mood	PF	802 US	HIGHWAY 20 EAST		(X5) COMPLETION DATE	
	time daily. A Physician No 9/19/10 indicate notified of the rinsomnia, very that she would The physician sthe Physician No 9/19/10 with or	tification form dated ed the physician was esident complaining of depressed and stated be better off dead. signed and returned lotification form on ders for the above ication to be initiated.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155344 03/28/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 802 US HIGHWAY 20 EAST LIFE CARE CENTER OF MICHIGAN CITY MICHIGAN CITY, IN46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE When interviewed on 3/24/11 at 1:03 p.m. Social Service Director indicated she was unaware of the statement made buy the resident on 9/19/10. The Social Service Director indicated a care plan should have been initiated when the resident made the statements and was started on antidepressant medication. 3.1-35(a) The services provided or arranged by the F0281 facility must meet professional standards of quality. F281 SS=D Based on observation, record review, F0281 04/27/2011 Resident #150 rinsed her mouth and interview, the facility failed to with water. No actual harm noted provide services to meet professional to resident. standards of care related to All residents on Advair Diskus instructing a resident to rinse her medication have the potential to be affected by the same deficient mouth correctly after the practice. All residents on Advair administration of an inhaler for 1 of 1 Diskus medication were audited receiving an inhaled medication of the to ensure directions on MAR 13 residents who were observed included "resident to rinse mouth with water and do not swallow". receiving medications by staff. Staff Development Coordinator (Resident #150) will audit 20% medication administration process weekly to Findings include: ensure nurses encourage resident to swish and not swallow The morning medication water after Advair is given. Licensed staff was in-serviced on administration pass was observed on proper medication administration 3/25/11 at 7:37 a.m. LPN #2 of Advair Diskus on 03/28/11. prepared an Advair Diskus inhaler for 04/06/11 and 04/12/11. Resident #150. The Advair Diskus Results of these audits will be inhaler was in a plastic bag from the presented at the monthly PI

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

V9QC11

Facility ID: 000236

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155344		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/28/2011	
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	pharmacy. The bag that read to water after ead swallow the water and primed the instructed their from the inhaler to the reinhaled the measked the residuater and hand glass of water. Instruct the residuater. The residuater and swallower and	ere was a label on the prinse the mouth with the use and do not ter. ed the resident's room inhaler. The LPN esident to take a puffer as she handed the esident. The resident dication. LPN #2 then lent if she wanted led the resident a The LPN did not ident to not swallow the ident drank the glass wallowed the water. In the ADVAIR.com ted the mouth was to water after breathing in and the user was to but. The water was not d. In the did not did not in the end of the mouth was to water after breathing in and the user was not d. In the water was not d.		Committee Meeting for 6 mon Plan to be amended as indicated per monthly review per PICommittee. Threshold of compliance will be 95% before discontinuing audits. The DON is responsible for ensuring ongoing compliance Compliance date 04/27/11.	ths. ted

000236

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155344		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/28/2011	
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	The services provifacility must be proin accordance with plan of care. Based on record the facility failed orders were followeekly skin assensuring follow completed with residents reviewand for 1 of 3 reange of motion criteria for rang sample of 40. (#58) Findings include: 1. The record for I on 3/28/11 at 9:15 and orders dated 11/4/recap dated 3/11 in to have a skin cheevery week on his Review of the 3/11 Record (MAR) indicated only signed out as 3/9/11. 3/2, 3/16, and Review of the Week Collection paper in was assessed on 3 month of March 20 month of March 2	ded or arranged by the ovided by qualified persons in each resident's written of the each resident's written of the each resident's written of the each resident's written over the doctor for 1 of 2 over for pressure ulcers esidents reviewed for in of the 7 who met the e of motion in the each exidents #37 and Resident #58 was reviewed for in the each exident exident was ck by a licensed nurse shower day-Wednesday. Medication Administration cated the skin check was a being completed on and 3/23/11 were all blank. Religible to the exident's skin exident's exident's skin exident's skin exident's exident's skin exident's exident's skin exident's exident's exident's skin exident's	1	CROSS-REFERENCED TO THE APPROPRIAT	DATE DATE 04/27/2011 ck. ece. ere by aff bluecks cs. edd ent an enthly of
		weekly skin assessments			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				
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TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	-	DATE
	were to be completed every Wednesday after the resident's shower by the nurse on that unit. The nurse was to complete the MAR as well as the Weekly Skin Integrity Data Collection paper.					
	on 3/23/11 at 9:30 fractured her right resident was then an orthopedic phys	cian visit to the orthopedic's				
	progress notes ind	3/10 Orthopedic Physician licated the resident was to in two months for a follow				
	the months of 10/1 indicated there wa	ohysician progress notes for 10, 11/10 and 12/10, s no documentation the back to see the orthopedic				
	indicated she had physician office by the last time the re	I #1 3/23/11 at 11:10 a.m., called the orthopedic request, and they verified esident had been to their /10. There was no follow				
	3.1-35(g)(2)					
F0309	must provide the r to attain or mainta physical, mental, a well-being, in acco					
SS=D		rvation, record review	F0309	F309 Resident #6 MD and family we		04/27/2011

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGAN CITY MAID SUMMARY SIATEMENT OF DEFICIENCIES PRIFIX TAG REQUIATOR YOLE CENTERTON INFORMATION and interview, the facility failed to identify and assess areas of bruising for 2 of 3 residents reviewed for non-pressure related skin conditions of the 3 residents who met the criteria for non-pressure related skin conditions of the 3 residents who met the criteria for non-pressure related skin conditions in the sample of 40. (Residents #6 and #132) Findings include: 1. On 3/22/11 at 8:51 a.m., Resident #132 was reviewed on 3/22/11 at 3:00 p.m. The resident's right wrist area. The record for Resident #132 was reviewed on 3/22/11 at 3:00 p.m. The resident's diagnoses included, but was not limited to, extensive skin breakdowns. There was no documentation in the Nursing Progress notes related to bruise and a Non-pressure Skin Condition Record had not been completed. A physician's order dated 3/16/11 indicated the resident was to receive 81 milligrams (mg) of Ecotrin (a coated Aspirin) daily. The physician's progress note dated 3/16/11, indicated the resident was anemic.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
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and family were notified of bruise. Skin check was completed on 03/28/11. Documentation of bruise noted in nurse's notes on 03/28/11. Documentation of bruise noted in nurse's notes on 03/28/11. Documentation of bruise noted in nurse's notes on 03/28/11. All residents who met the criteria for non-pressure related skin conditions in the sample of 40. (Residents #6 and #132) Findings include: Findings include: 1. On 3/22/11 at 8:51 a.m., Resident #132 was observed seated in the hallway in her wheelchair. A small area of bruising was observed on the resident's right wrist area. The record for Resident #132 was reviewed on 3/22/11 at 3:00 p.m. The resident's diagnoses included, but was not limited to, extensive skin breakdowns. There was no documentation in the Nursing Progress notes related to a bruise and a Non-pressure Skin Condition Record had not been completed. A physician's order dated 3/16/11 indicated the resident was to receive 81 milligrams (mg) of Ecotrin (a coated Aspirin) daily. The physician's progress note dated 3/16/11,		identify and as	sess areas of bruising					
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Skin checks will be audited weekly by DON/Designee. Licensed staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 on completing skin checks weekly. The record for Resident #132 was reviewed on 3/22/11 at 3:00 p.m. The resident's diagnoses included, but was not limited to, extensive skin breakdowns. There was no documentation in the Nursing Progress notes related to a bruise and a Non-pressure Skin Condition Record had not been completed. A physician's order dated 3/16/11 indicated the resident was to receive 81 milligrams (mg) of Ecotrin (a coated Aspirin) daily. The physician's progress note dated 3/16/11,		 Findings includ	la.					
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The record for Resident #132 was reviewed on 3/22/11 at 3:00 p.m. The resident's diagnoses included, but was not limited to, extensive skin breakdowns. There was no documentation in the Nursing Progress notes related to a bruise and a Non-pressure Skin Condition Record had not been completed. A physician's order dated 3/16/11 indicated the resident was to receive 81 milligrams (mg) of Ecotrin (a coated Aspirin) daily. The physician's progress note dated 3/16/11,		area of bruising	g was observed on the					
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was not limited to, extensive skin breakdowns. There was no documentation in the Nursing Progress notes related to a bruise and a Non-pressure Skin Condition Record had not been completed. A physician's order dated 3/16/11 indicated the resident was to receive 81 milligrams (mg) of Ecotrin (a coated Aspirin) daily. The physician's progress note dated 3/16/11,			•				.00	
breakdowns. There was no documentation in the Nursing Progress notes related to a bruise and a Non-pressure Skin Condition Record had not been completed. A physician's order dated 3/16/11 indicated the resident was to receive 81 milligrams (mg) of Ecotrin (a coated Aspirin) daily. The physician's progress note dated 3/16/11,			•					
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There was no documentation in the Nursing Progress notes related to a bruise and a Non-pressure Skin Condition Record had not been completed. A physician's order dated 3/16/11 indicated the resident was to receive 81 milligrams (mg) of Ecotrin (a coated Aspirin) daily. The physician's progress note dated 3/16/11,		Dieakuowiis.				_		
Nursing Progress notes related to a bruise and a Non-pressure Skin Condition Record had not been completed. A physician's order dated 3/16/11 indicated the resident was to receive 81 milligrams (mg) of Ecotrin (a coated Aspirin) daily. The physician's progress note dated 3/16/11,		There was re-	decumentation in the			· ·		
bruise and a Non-pressure Skin Condition Record had not been completed. A physician's order dated 3/16/11 indicated the resident was to receive 81 milligrams (mg) of Ecotrin (a coated Aspirin) daily. The physician's progress note dated 3/16/11,								
Condition Record had not been completed. A physician's order dated 3/16/11 indicated the resident was to receive 81 milligrams (mg) of Ecotrin (a coated Aspirin) daily. The physician's progress note dated 3/16/11,						Compliance date 04/27/11.		
completed. A physician's order dated 3/16/11 indicated the resident was to receive 81 milligrams (mg) of Ecotrin (a coated Aspirin) daily. The physician's progress note dated 3/16/11,			•					
A physician's order dated 3/16/11 indicated the resident was to receive 81 milligrams (mg) of Ecotrin (a coated Aspirin) daily. The physician's progress note dated 3/16/11,			ord had not been					
indicated the resident was to receive 81 milligrams (mg) of Ecotrin (a coated Aspirin) daily. The physician's progress note dated 3/16/11,		completed.						
indicated the resident was to receive 81 milligrams (mg) of Ecotrin (a coated Aspirin) daily. The physician's progress note dated 3/16/11,								
81 milligrams (mg) of Ecotrin (a coated Aspirin) daily. The physician's progress note dated 3/16/11,		A physician's o	rder dated 3/16/11					
coated Aspirin) daily. The physician's progress note dated 3/16/11,		indicated the re	esident was to receive					
coated Aspirin) daily. The physician's progress note dated 3/16/11,								
progress note dated 3/16/11,		, , ,						
1 0 0 0 0 0 0 0 1 1 1 1 1 1 1 1 1 1 1 1		· •						
i noncaled the regident was abernic to the first transfer of the f		81 milligrams (coated Aspirin) progress note	mg) of Ecotrin (a daily. The physician's dated 3/16/11,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155344	B. WIN			03/28/2	011
		II.	P. (12)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			HIGHWAY 20 EAST		
LIFE CA	RE CENTER OF MI	CHIGAN CITY			GAN CITY, IN46360		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The Plan of Careviewed 2/11, was at risk for sto decreased mincontinence, at the intervention. The intervention. Skin check dares as a second licensed staff. Monitor orders and listed on the Order Summar skin check was Licensed Nurses shower day, what he 6-2 shift. Review of the Notate Collection 3/14, and 3/21/2 resident's skin bruises were decreased out 3/14, and 3/21/2 and 3/	are dated 11/22/10 and indicated the resident skin breakdown related nobility, bladder and receives Ecotrin. Ins were as follows: ily with care devery week per sed labs ruising, blood in stool, order dated 11/13/10 and 3/11 Physician's ry (POS), indicated a se to be completed by a se every week on hich was Monday on Weekly Skin Integrity sheets dated 3/7, 11, indicated the was intact and no ocumented. In the Licensed Nurse is as completed 3/7, 11.					
	On 3/24/11 at 1	1:34 p.m., the resident					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED		
		155344	B. WIN	G		03/28/2011		
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	\neg	
NAME OF I	KOVIDEK OK SOLI EIEK			802 US	HIGHWAY 20 EAST			
LIFE CAF	RE CENTER OF MI	CHIGAN CITY		MICHIG	GAN CITY, IN46360			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
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TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	\dashv	
		n bed. The bruising						
		e resident's right wrist						
		with CNA #4 at the						
	· ·	that she was not						
	1	ecent falls for the						
	resident and the							
		wrist area was old.						
		vhenever a bruise or						
		bserved, the Nurse						
		d a Nurse Alert form						
	was completed	•						
	الملامة الملام	DN #0 an 2/24/44 at						
		PN #2 on 3/24/11 at						
	· •	ated when bruises or						
		observed, the CNA's						
		now and a Nurse Alert						
		leted. The LPN						
		he had performed a						
		he resident that						
		othing was observed.						
		ne resident's right wrist						
	· ·	observed the area of						
		n asked how she got						
	l '	resident indicated she						
	~	n her tablemate fell						
		and her hand hit the						
	table. The LPN							
		mate fell Sunday						
		asked if a Nurse Alert						
		ve been completed,						
		ted the CNA's probably						
		due to the resident's						
	age spots.							
	An anter	at agreement at and the state						
	An entry was n	ot completed in the						

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155344	B. WIN			03/28/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY			HIGHWAY 20 EAST SAN CITY, IN46360		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	T	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	at 9:00 a.m. A Condition Reco 3/28/11 which in had a discoloratinght wrist.	ss Notes until 3/28/11 Non-pressure Skin ord was initiated on ndicated the resident tion to the top of the					
SS=D	on 3/28/11 at 1 entry was comprogress Notes Skin Condition on 3/28/11 rath 2. On 3/21/11 at was observed sittii room. There was resident's right har	he Director of Nursing 1:00 a.m., indicated an bleted in the Nursing and a Non-Pressure Record was initiated er than on 3/24/11. 10:10 a.m., Resident #6 ng in a wheel chair in her a bruise to the top of the nd. The bruise was m. (centimeters) in			F309 Resident #6 MD and family we notified of bruise on 03/23/11. Skin check was completed.Resident #132 MD	ere	04/27/2011
	approximately 3 cm. (centimeters) in diameter. The record for Resident #6 was reviewed on 3/23/11 at 8:04 a.m. The resident's diagnoses included, but were not limited to, osteoarthrosis, polymyalgia rheumatica, muscle weakness, and high blood pressure. The 3/11 Physician Order Statement indicated there was an order for the resident to receive two tablets of aspirin 81 milligrams daily. There was also a physician's order for a skin check to be performed by a licensed nurse every week on the resident's shower day. A care plan initiated on 3/16/10 and last updated with a goal date of 6/11/11 indicated the resident was at risk for skin breakdown as the resident was receiving Aspirin and Prednisone medications daily. Care plan interventions included for weekly skin checks by licensed staff and for staff to observe for				and family were notified of bru Skin check was completed on 03/28/11. Documentation of bruise noted in nurse's notes of 03/28/11. All residents have the potential be affected by the same deficie practice. All skin checks were audited for completeness. Skin checks will be audited weekly by DON/Designee. Licensed staff was in-serviced 03/28/11, 04/06/11 and 04/12/0 on completing skin checks weekly. Results of the audits will be presented at monthly Performance Improvement Committee Meeting for 6 mont Plan to be amended as indicated per monthly review per Pl	on I to ent on 11	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155344		A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPLI 03/28/20	ETED	
NAME OF PROVIDER	OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 20 EAST	00/20/20	,,,,
LIFE CARE CENT	TER OF MIC	CHIGAN CITY		MICHIG	GAN CITY, IN46360		
PREFIX (EA	CH DEFICIENO	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
and reports of the staff was no top of the staff was present blank of the staff was no assessive were considered and 3/2 sheets present blank of the staff was bruised there for staff was bruises Nurses assessive was no assessive was not	ort bruises. If Nurses' Note that completed or existent at the section the above on the resident at the existent at the exist	Notes were reviewed. There ation of the bruise on the s right hand. Weekly Skin ection sheets for 3/11 were eets indicated assessments in 3/1/11, 3/8/11, 3/15/11, in e was a section on the eany bruises that were on to mark bruises was in 6 four dates. On 3/23/11 at 10:25 a.m., she was assigned to care this time and on the 3/21/11 indicated she thought the ent's right hand had been the LPN indicated nursing the physician of new ruises by charting in the on the weekly skin is. LPN #1 indicated the tetop of the resident's hand ed on the weekly skin		inu	Committee. Threshold of compliance will be 95 % before discontinuing audits. The DON is responsible for ensuring ongoing compliance. Compliance date 04/27/11.	e	DALE

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAIN	OF CORRECTION	155344	A. BUILI		00	03/28/2	
		100044	B. WING		DDDEGG CITY CTATE ZID CODE	00/20/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY			SAN CITY, IN46360		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	right hand.						
	3.1-37(a)						
F0314	a resident, the factoresident who enterpressure sores do sores unless the indemonstrates that and a resident have receives necessar promote healing, prevent new sores				5044		
SS=D	prevent new sores from developing. Based on observation, record review, and interview, the facility failed to ensure residents who currently had pressure ulcers received the appropriate treatments to promote healing related to ensuring weekly skin assessments were completed for a resident who was at risk for pressure ulcers and for completing the correct treatment for a resident with a pressure ulcer for 2 of 2 residents reviewed for pressure ulcers in the sample of 40. (Residents #49 and #58) Findings include: 1. On 3/28/11 at 9:25 a.m. Resident #58 was observed in bed. At that time LPN #3 was providing a treatment to the resident. The resident's left heel was observed with a pressure ulcer. The pressure ulcer		F03	314	F314 Resident #58 skin was assess on 03/28/11, proper treatment applied.Resident #49 now receives the appropriate treatment. All residents have the potentia be affected by the same deficie practice. All residents who are risk for skin breakage will be assessed. Those with pressure ulcers will have weekly skin checks and correct treatments applied. TAR/Skin check audits will be conducted weekly by DON/Designee. Licensed nurs staff was in-serviced on 03/28/04/06/11 and 04/12/11 by Nurs Administration regarding week skin assessments and comple correct treatments. The DON/Designee will audit the TARS/Skin checks weekly. Results of these audits will be presented at the monthly PI Committee Meeting for 6 mont Plan to be amended as indicated.	I to ent at e ing ing ly ting	04/27/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: V9QC11 Facility ID:

000236

If continuation sheet

Page 60 of 91

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155344	B. WING		03/28/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
LIEE CAI	RE CENTER OF MI	CUICAN CITY		S HIGHWAY 20 EAST GAN CITY, IN46360	
				3AN CITT, IN40300	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
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1710		ave 100 % black	i i i i i i i i i i i i i i i i i i i	per monthly review per PI	Ditte
		ea was not opened nor		Committee. Threshold of	
		drainage noted. The		compliance will be 95 % before	re
	•	a measurement of the		discontinuing audits. The DON is responsible for	
		re ulcer. The area		ensuring ongoing	
	-	centimeters (cm) by 5		compliance.Compliance date	
		applied granulex to the		04/27/11.	
	left heel.				
	The record for I	Resident #58 was			
	reviewed on 3/2	28/11 at 9:15 a.m. The			
	resident's diagr	noses included, but			
	were not limited	d to, vascular dementia			
	with psychotic f	eatures, muscle			
	weakness, late	effect stroke, chronic			
	hepatitis, and fr	requent falls.			
	Review of nurs	ing progress notes,			
	dated 3/25/11 a	nt 8:00 a.m., indicated			
		d complained of			
		he left heel. Physical			
		ssessed the resident's			
		5/11 at 9:14 a.m., and			
	indicated "disch	• .			
		treat order, area to left			
		hard eschar and no			
	•	on. Communicated			
		an to leave area alone			
		any indication of			
		ble, boggy end feel, or			
	_	kin condition, heels up			
		for pressure relief to /aluate if appropriate."			
	i area. VVIII 16-6\	ναιμαίο η αμμιθμησίο.			
	Review of the o	are plan, dated 8/9/10			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155344		(X2) MULTIP A. BUILDING B. WING		NSTRUCTION 00	(X3) DATE S COMPL 03/28/2	ETED	
	PROVIDER OR SUPPLIER		STI 80	2 US	DDRESS, CITY, STATE, ZIP CODE HIGHWAY 20 EAST		
	RE CENTER OF MI				AN CITY, IN46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	TIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	skin breakdown mobility and bo incontinence. approaches we weekly per lice	esident was at risk for n related to decreased wel and bladder The nursing ere to assess the skin					
	and on the curren indicated the resid	t recap dated 3/11, dent was to have a skin ed nurse every week on his					
	Record (MAR) ind only signed out as	Medication Administration icated the skin check was being completed on nd 3/23/11 were all blank.					
	Collection paper i	ekly Skin Integrity Data ndicated the resident's skin 3/9/11. The rest of the 011 was blank.					
	dated 3/10/10 indi	den scale assessment cated a score of 14 which sk for pressure ulcers.					
	a.m., indicated the were to be comple the resident's sho unit. The nurse w	N#2 on 3/28/11 at 10:15 weekly skin assessments eted every Wednesday after wer by the nurse on that as to complete the MAR as y Skin Integrity Data					
SS=D	2. Resident #4 seated in a who 8:53 a.m. There	9 was observed eelchair on 3/23/11 at e was a wound vac ned to the resident's			F314 Resident #58 skin was assess on 03/28/11, proper treatment applied.Resident #49 now receives the appropriate	ed	04/27/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	L DIIII	LDING	00	COMPL	ETED
		155344	1			03/28/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1			
		IOLUGANI OLTV		1	HIGHWAY 20 EAST		
LIFE CAI	RE CENTER OF MI	ICHIGAN CITY		MICHIC	GAN CITY, IN46360		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	wheelchair.				treatment.		
					All residents have the potentia		
	The record for Resident #49 was				be affected by the same defici		
		23/11 at 9:23 a.m. The			practice. All residents who are	at	
					risk for skin breakage will be		
		agnoses that included,			assessed. Those with pressur ulcers will have weekly skin	ا	
		mited to, fracture left			checks and correct treatments	.	
		illness with associated			applied.	.	
	1	nptoms, pressure ulcer			TAR/Skin check audits will be		
	left heel and de	ementia.			conducted weekly by		
					DON/Designee. Licensed nurs	sing	
	Review of the f	form titled "Weekly			staff was in-serviced on 03/28	· /	
		Tracking Report,"			04/06/11 and 04/12/11 by Nurs		
		indicated the resident			Administration regarding week		
		(full tissue thickness			skin assessments and comple	ting	
	•	•			correct treatments. The		
	l ' '	sore that was 3.8 cm			DON/Designee will audit the TARS/Skin checks weekly.		
	, , , , , , , , , , , , , , , , , , ,	by 3.0 cm by .3 cm in			Results of these audits will be		
		ssure sore was on the			presented at the monthly PI		
	resident's left h	neel.			Committee Meeting for 6 mon	ths.	
					Plan to be amended as indicate		
	There was a pl	hysician's order dated			per monthly review per PI		
		wound care to the left			Committee. Threshold of		
		ician's order indicated			compliance will be 95 % before	е	
	1	py was to complete the			discontinuing audits.		
	1	• •			The DON is responsible for		
		h included sharp			ensuring ongoing compliance.Compliance date		
	debridement w				04/27/11.		
	· .	rs/scalpel, cleanse with			04/27/11.		
		apply Santyl ointment,					
	dress with wou	ınd vac (negative					
	pressure vacuu	um) 3 x week Monday,					
	Wednesday an	nd Friday. Nursing staff					
	l	eeded) for soiled or not					
		und vac was to be set					
	at 125 mm/hg (millimeters of						
		(minimiciers of					
	mercury).						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 03/28/2	ETED
NAME OF I	PROVIDER OR SUPPLIE	 			ADDRESS, CITY, STATE, ZIP CODE	!	
					HIGHWAY 20 EAST		
LIFE CARE CENTER OF MICHIGAN CITY				L	GAN CITY, IN46360		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	The wound tre	atment to the resident's					
	left heel was o	bserved on 3/23/11 at					
	9:45 a.m. The	resident was observed					
	1	g on her right side. The					
	1	pist #1 removed the					
	_	the resident's left heel.					
	1	vas attached to the					
		ing. The wound and the odrainage. The					
	_	pist #1 indicated the					
	1 -	cm by 2.4 cm in size.					
		the wound was a stage					
		yellow slough in the					
	center and an	area of brown tissue in					
	the very center	of the wound, .5 cm in					
	1	ical Therapist #1					
		ound with normal					
		en debrided the wound					
		and scissor. The					
	1 -	ipist #1 then applied					
		nd the wound vac					
		t the wound vac to 125 d not apply Santyl					
	ointment to the						
	Interview with	Physical Therapist #1					
	at 10:51 a.m. o	on 3/23/11 indicated					
	she did not ap	oly Santyl ointment to					
		vound during the					
	pressure sore						
		hysician order dated					
	•	escribe Santyl ointment					
		o the wound. She					
		hysician's order written					
	011 3/ 18/11 Was	s not transcribed to the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344	(X2) MULTIPI A. BUILDING B. WING	E CONSTRUCTION 00		(X3) DATE SU COMPLE 03/28/20	TED
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY,			
LIFE CAF	RE CENTER OF MI	CHIGAN CITY		US HIGHWAY 20 CHIGAN CITY, IN4			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDE	ER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X (EACH CORRE CROSS-REFERE	ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAU		t Administration	IAC				DATE
	`	e was unaware of the					
	physician's ordointment.	er to use Santyl					
		March 2011 TAR at					
		3/23/11 indicated the					
		er written on 3/18/11 ribed to the TAR.					
		red on 3/23/11 at 3:18					
	p.m. the DoN (Director of Nursing) indicated the physician's order should						
		scribed to the TAR.					
		ited the Physical nould have applied the					
	•	t as ordered by the					
	physician.	•					
	3.1-40(a)(1) 3.1-40(a)(2)						
F0315	assessment, the faresident who ente indwelling cathete	dent's comprehensive acility must ensure that a rs the facility without an r is not catheterized unless cal condition demonstrates					
	that catheterizatio	n was necessary; and a continent of bladder					
		ate treatment and services tract infections and to					
		ormal bladder function as					
SS=D		rvation, record review,	F0315	F315 Resident #1	37 foley catheter is		04/27/2011
		he facility failed to nt and services were		a protective	bag and suspende		
		vent urinary tract		off floor. All residents	s with foley cathete	r	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155344	B. WIN			- 03/28/2011	
		1	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1	HIGHWAY 20 EAST		
LIEE CA	LIFE CARE CENTER OF MICHICAN CITY			1	GAN CITY, IN46360		
LIFE CARE CENTER OF MICHIGAN CITY			WIICITIC	SAN CITT, IN40300			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		
TAG	+	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
	infections for 1	of 4 residents			have the potential to be affected		
	reviewed for in	dwelling foley catheters			by the same deficient practice residents with foley catheters	. All	
	of the 4 reside	nts who met the criteria			were audited. No other		
	for foley cathet	ters in the sample of			deficiencies were noted.		
	40.				All foley catheters will be audit	ed	
	(Resident # 13	7)			daily M-F to ensure they are ir		
		,			protective covers and off the fl	oor	
	Findings includ	de:			by DON/Designee. Staff was in-serviced on 03/28/11, 04/06 and 04/12/11by Nursing	/11	
	On 3/21/11 at 3	2:02 p.m., Resident			Administration regarding keep	ing	
		erved in bed. The			foley catheter in bag and not o	- I	
		foley catheter in place.			floor.		
		eter drainage bag was			Results of audits will be		
	1				presented at monthly PI		
	_	floor. The drainage bag			Committee meeting for 6 month	l l	
	1	otective or dignity bag.			Plan to be amended as indicate per monthly review per Pl	leu	
		as not receiving any			Committee. Threshold of		
	care from staff	at this time.			compliance will be 95% before	,	
					discontinuing audits.		
	On 3/22/11 at 8	8:44 a.m., Resident			The DON is responsible for		
	#137 was obse	erved in bed. The			ensuring ongoing compliance.		
	resident had a	foley catheter in place.			Compliance date 04/27/11.		
		eter drainage bag was					
	1	floor. The drainage bag					
		otective or dignity bag.					
	!	as not receiving any					
	care from staff	9 9					
	Care IIOIII Stall	at this time.					
	On 2/22/44 at 6	2:20 n m Dooidant					
		2:28 p.m., Resident					
	#137 was observed in bed. The resident had a foley catheter in place. The foley catheter drainage bag was						
	resting on the	floor. The drainage					
	bag was not in	a protective or dignity					
	_	ent was not receiving					
	-	staff at this time.					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155344	A. BUILDING B. WING	03/28/2011		
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGAN CITY			STREET 802 US	ADDRESS, CITY, STATE, ZIP CODE S HIGHWAY 20 EAST GAN CITY, IN46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	The facility police Catheters" was Staff Developm at 2:00 p.m. The as a current information of the policy was 5/21/2004. The foley catheter content of the floor when interview a.m., the Direct	cy titled "Urinary received from the ent Nurse on 3/24/11 ne policy was identified ection control policy. last revised on e policy indicated the ollection bags were to or. eed on 3/24/11 at 11:00 or of Nursing indicated er bag should not				
F0325	assessment, the faresident - (1) Maintains accenutritional status, sprotein levels, unlead condition demonstrations and	ent's comprehensive acility must ensure that a septable parameters of such as body weight and less the resident's clinical trates that this is not erapeutic diet when there is				
SS=D	Based on recordinterviews, the a significant we percent in the paddressed by the Manager and the for 1 of 3 resides	d review and facility failed to ensure ight loss of five	F0325	F3251.) Resident #102 weight loss was addressed on 03/17/ and his Care Plan created on 03/24/11.2.) All residents with weight loss have the potential be affected by the same deficipractice. The Dietary Manager conducted an audit of resident with weight loss to ensure Dieterood Manager and Registered	to ent s tary	

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Event ID: V9QC11 Facility ID:

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´		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	00	COMPLETED		
		155344	B. WIN	IG		03/28/2011	
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		\Box
TWINE OF I	NO VIDEN ON BOTTEREN			1	HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY		MICHIG	GAN CITY, IN46360		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	\Box
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	ᆜ
		he sample of 40.			Dietician has addressed them.	3.)	
	(Resident #102	2)			All residents with significant weight losses will be audited		
					monthly by the Dietary Manag	er	
	Findings include:				and registered Dietician. Weig		
	The record for Dec	sident #402 was reviewed			losses will be addressed with		
		sident #102 was reviewed a.m. The resident's			appropriate interventions. Stat	f	
		ed, but were not limited to,			was in-serviced on 03/28/11,		
	•	f fall, abnormality of gait,			04/06/11 and 04/12/11 on addressing significant weight		
		, coronary artery disease,			losses with proper		
		betes, frontal lobe apraxia,			interventions.4.) Results of au	dits	
	cancer of prostate	ronic renal failure, and			will be presented at monthly P		
	cancer or prostate	Weeting. The should be compliant			nce		
	The resident was admitted to the facility from				will be at 95% before discontinuing audits.5.) Dietar	,	
		20/11. The recorded weight			Manager is responsible for		
		as 195 pounds at that time.			ensuring ongoing compliance.		
		sident's weight was recorded			Compliance date 04/27/11.		
	·	10 pound weight loss in five ecorded weight was 182					
		The resident was again					
		and weighed 165 pounds					
	(a 30 pound weigh	nt loss in 20 days).					
	Deview of the Nut	rition Interview Program					
		cated the resident was seen					
		ound weight loss in seven					
	·	The Registered Dietitian					
		add 3 ounce med pass 2.0					
	· . ·	nt's diet due to the weight					
	loss.						
	Review of physicia	an orders dated 1/31/11					
	(four days after the	e recommendation)					
	·	s 2.0, 4 ounces was added					
	twice a day.						
	Further review of t	he Nutrition Interview					
		ndicated the resident was					
	seen on 2/2/11 and	d no recommendations					
	were made, and o	n 2/10/11 and no					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ĺ	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE :	ETED
		155344	B. WIN	G		03/28/2	011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
LIFE CARE CENTER OF MICHIGAN CITY				1	HIGHWAY 20 EAST SAN CITY, IN46360		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	2/10/11 report, the recorded as 165 president had lost 1 review. The Regis	were made. On the current weight was rounds and it was noted the 17 pounds since the last stered Dietitian had not in the 2/2 or the 2/10/11					
	the next time the foreviewed the residual 3/17/11. The RD is lost 6.5% weight in a significant weigh recommended to it.	Progress Notes indicated Registered Dietitian (RD) Ient's chart was not until indicated the resident had in the last month which was not loss. The RD then increase the resident's med is to three times a day to ain.					
	There was no care unplanned weight	e plan initiated for the loss.					
	Policy indicated "A experiences an ur significant weight weight change is a the interdisciplinar a weight change hassessment/progr Interdisciplinary C the root cause of tor weight gain, as indicated, provide goals, indicates sp interventions, and	rplanned weight loss, change, or undesirable assessed and monitored by ty team. Each resident with lass a current nutrition less note. The lare Plan team addresses the weight loss/poor intake sesses dining needs if se realistic and measurable pecific and individualized more as needed"					
	indicated she was 2/14, 2/17, 2/19, 2 at the facility in Ma and then on 3/24/	RD on 3/24/11 at 3:30 p.m., at the facility on 2/4, 2/10, 2/21, 2/24/11. She was also arch on 3/3, 3/10, 3/17/11, 11. The RD indicated that of the resident's 20 pound					

l l		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344	(X2) MULTIPLE CC A. BUILDING B. WING	00	ľ	E SURVEY PLETED (2011
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CO HIGHWAY 20 EAST BAN CITY, IN46360	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	recommendations given the informat significant amount Interview with the 3/24/11 at 3:35 p.r of the resident's 2/2/9/11 since admis why there were no made when he wa Interview Program 3.1-46(a)(1)					
F0329	from unnecessary drug is any drug with dose (including duscessive duration monitoring; or with for its use; or in the consequences who have reduced or discombinations of the Based on a compresident, the faciliar residents who have drugs are not give antipsychotic drug treat a specific condocumented in the residents who use	· •				
SS=D	behavioral interve contraindicated, ir these drugs.	ntions, unless clinically an an effort to discontinue dreview and interview,	F0329	F329 Resident #5 received F	PRN	04/27/2011
FORM CMS-2	2567(02-99) Previous Versio	ons Obsolete Event ID:	V9QC11 Facility			age 70 of 91

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155344 03/28/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 802 US HIGHWAY 20 EAST LIFE CARE CENTER OF MICHIGAN CITY MICHIGAN CITY, IN46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE the facility failed to ensure 3 of 10 laxative. No actual harm noted.Resident #13 vital signs are residents who were reviewed for monitored weekly per MD order. unnecessary drugs in the sample of Resident #144 antipsychotic was 40 had their drug regimen free from discontinued. unnecessary drugs related to All residents have a potential to be affected by the same deficient monitoring bowel movements and the practice. Audits will be conducted administration of as needed (prn) ensuring Rita is checked before laxatives, indication for the use of an giving PRN laxatives, vital signs anti-psychotic medication and are taken per physician's order monitoring blood pressure and heart and antipsychotic have appropriate diagnosis. rate prior to giving cardiac BM, vitals, antipsychotics will be medications. (Residents #5, #13 and audited weekly by #144) DON/Designee. Staff was in-serviced on 03/28/11, 04/06/11 Findings include: and 04/12/11 on checking Rita prior to PRN laxative use, getting vitals per MD order for cardiac 1. The record for Resident #5 was meds, and providing proper reviewed on 3/23/11 at 10:30 a.m. diagnosis for antipsychotics. The resident's diagnoses included, Results of audits will be presented at monthly PI but was not limited to, constipation. Committee meeting for 6 months. Plan to be amended as indicated The bowel movement protocol listed per monthly review per PI on the December 2010, January and Committee. Threshold of February 2011 Medication compliance will be 95% before discontinuing audits. Administration Records (MAR's), The DON is responsible for indicated record BM (bowel ensuring ongoing compliance. movement) each shift, give prescribed Compliance date 04/27/11. prn laxative if no BM in 3 days or call MD (physician). A Physician's order dated 2/9/10 and listed on the December 2010, January, February and March 2011 Physician's Order Summaries, indicated the resident was to receive

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S	ETED
		155344	B. WIN	G		03/28/2	011
NAME OF I	PROVIDER OR SUPPLIER	2		1	ADDRESS, CITY, STATE, ZIP CODE		
LIFE CA	RE CENTER OF MI	CHIGAN CITY		1	HIGHWAY 20 EAST GAN CITY, IN46360		
(X4) ID				ID	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		(V5)
PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	Milk of Magnes	sia Suspension (a					
	laxative) 30 mi	lliliters (ml) once a day					
	,	no results in 24 hours,					
	call Physician f	for further orders).					
	 The 12/10 MAI	R, indicated the					
		bowel movement on					
		e 2-10 shift. The "Rita"					
	computer syste	em where the CNA's					
	input their infor	mation, indicated the					
	resident did not have a bowel movement on the evening shift on 12/13/10. The resident received the						
	1 .	gnesia on 12/15/10 at					
	2:00 p.m. The	esident had two large					
		bowel movement on					
		nall bowel movement					
		he MAR indicated the					
	resident had no	bowel movements					
	12/16-12/18/11	and the prn Milk of					
	1	given on 12/19/10 at					
	7:00 a.m.						
	 The 1/11 MAP	, indicated the resident					
		bowel movement for all					
		-1/10/11. The resident					
	received the pr	n Milk of Magnesia on					
		n. and on 1/10/11 at					
	8:00 a.m. Rev	iew of the "Rita" report					
		11, indicated the					
		medium bowel					
		the evening shift on					
	1/8/11 and a m						
	movement on t	the night shift on					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155344		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 03/28/2	ETED	
	ROVIDER OR SUPPLIEF			802 US	DDRESS, CITY, STATE, ZIP CODE HIGHWAY 20 EAST	•	
LIFE CAF	RE CENTER OF MI	CHIGAN CITY		MICHIG 	SAN CITY, IN46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	documented as bowel movements on MAR indicated have a bowel reshifts 1/18-1/2 Magnesia was 2:00 a.m. The the resident har movement on the and a medium the evening shull be a movement on the e	1/12/11. The 1/11 the resident did not novement all three I/11 and the prn Milk of given on 1/22/11 at "Rita" report indicated d a small bowel he day shift on 1/21 bowel movement on					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPI	
		155344	B. WIN	G		03/28/2	011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	-	
		OLUGANI OLTI		1	S HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY		MICHIC	GAN CITY, IN46360		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	a BM within the	e 3 days.					
		he Director of Nursing					
		0:00 a.m., indicated					
		icting information on					
	the MAR and th	ne "Rita" related to					
	bowel moveme	nts and the resident					
	did not receive	her prn MOM as					
	ordered.						
SS=D	The record f	or Resident #144 was			F329		04/27/2011
	reviewed on 3/2	23/11 at 1:10 p.m. The			Resident #5 received PRN		
	resident's diagr	noses included, but			laxative. No actual harm noted.Resident #13 vital signs	are	
	were not limited	d to, status post			monitored weekly per MD orde		
	aspiration pneu	ımonia, respiratory			Resident #144 antipsychotic w		
	failure, hypokal	emia, anxiety, GERD,			discontinued.		
	osteoarthritis, le	eukocytosis,			All residents have a potential t		
		culty in walking,			be affected by the same defici practice. Audits will be conducted		
		ess, hemiparesis,			ensuring Rita is checked before		
	history of a stro				giving PRN laxatives, vital sign		
	,				are taken per physician's orde		
	Review of Phys	sician orders dated			and antipsychotic have		
	_	el (an antipsychotic)			appropriate diagnosis.	20	
	•	ng) by mouth every			BM, vitals, antipsychotics will I audited weekly by	Je	
	night.	3, 1, 111 1 1,			DON/Designee. Staff was		
	· · · · · · ·				in-serviced on 03/28/11, 04/06	5/11	
	Review of phys	ician notification form			and 04/12/11 on checking Rita		
		7 p.m. indicated			prior to PRN laxative use, gett	-	
		s the Ambien (a			vitals per MD order for cardiac meds, and providing proper	;	
		kes helps him fall			diagnosis for antipsychotics.		
	• •	loesn't sleep more			Results of audits will be		
	•	nt. He would like to			presented at monthly PI		
	_	try 25 mg of Seroquel			Committee meeting for 6 months		
		Ambien to help him			Plan to be amended as indicate per monthly review per Pl	ted	
	•	•			Committee. Threshold of		
		leeds something for			compliance will be 95% before)	
	uepression rela	ited to diagnosis of					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155344 03/28/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 802 US HIGHWAY 20 EAST LIFE CARE CENTER OF MICHIGAN CITY MICHIGAN CITY, IN46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE ALS. discontinuing audits. The DON is responsible for ensuring ongoing compliance. The Nurse Practitioner reviewed the Compliance date 04/27/11. fax form on 3/16/11 and wrote the order for the Seroquel; however, there was no diagnosis for the indication for its use. Interview with RN#1 on 3/23/11 at 1:50 p.m. indicated there was no diagnosis for the Seroquel. Further interview with RN #1 indicated another nurse had suggested to the resident that he try Seroquel for sleep. SS=D 3. The record for Resident #13 was 04/27/2011 Resident #5 received PRN reviewed on 3/24/11 at 11:53 a.m. laxative. No actual harm The resident's diagnoses included, noted.Resident #13 vital signs are but were not limited to, hemiplegia monitored weekly per MD order. (weakness of the extremities), senile Resident #144 antipsychotic was discontinued. dementia, convulsions, and All residents have a potential to depressive disorder. be affected by the same deficient practice. Audits will be conducted Review of the 3/11 Physician Order ensuring Rita is checked before Statement indicated there was an giving PRN laxatives, vital signs are taken per physician's order order for the resident to receive and antipsychotic have Metoporol 25 milligrams one tablet appropriate diagnosis. daily. The order also indicated the BM. vitals, antipsychotics will be Metoporol was to held if the resident's audited weekly by heart rate was less the 55 or the DON/Designee. Staff was in-serviced on 03/28/11, 04/06/11 systolic (upper number) BP (blood and 04/12/11 on checking Rita pressure) was less the 100. prior to PRN laxative use, getting vitals per MD order for cardiac The 3/11 Medication Administration meds, and providing proper diagnosis for antipsychotics. Record indicated the resident

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Event ID: V9QC11

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 802 US HIGHWAY 20 EAST LIFE CARE CENTER OF MICHIGAN CITY MICHIGAN CITY, IN46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION COMP	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155344		A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 03/28/2	ETED		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) received the Metoporol 25 milligrams daily at 8:00 a.m. 3/1/11 through 3/24/11. The resident's heart rate was not recorded on any of the above dates. The only dates the resident's blood pressure reading was recorded on the 6:00 a.m. to 2:00 p.m. shifts were on 3/3/11, 3/7/11, 3/14/11,				STREET ADDRESS, CITY, STATE, ZIP CODE 802 US HIGHWAY 20 EAST					
received the Metoporol 25 milligrams daily at 8:00 a.m. 3/1/11 through 3/24/11. The resident's heart rate was not recorded on any of the above dates. The only dates the resident's blood pressure reading was recorded on the 6:00 a.m. to 2:00 p.m. shifts were on 3/3/11, 3/7/11, 3/14/11, Results of audits will be presented at monthly PI Committee meeting for 6 months. Plan to be amended as indicated per monthly review per PI Committee. Threshold of compliance will be 95% before discontinuing audits. The DON is responsible for ensuring ongoing compliance.	(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	T	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
3/24/11. The resident's heart rate was not recorded on any of the above dates. The only dates the resident's blood pressure reading was recorded on the 6:00 a.m. to 2:00 p.m. shifts were on 3/3/11, 3/7/11, 3/14/11, Committee meeting for 6 months. Plan to be amended as indicated per monthly review per Pl Committee. Threshold of compliance will be 95% before discontinuing audits. The DON is responsible for ensuring ongoing compliance.	TAG	 	· · · · · · · · · · · · · · · · · · ·		TAG	Results of audits will be	TE .	DATE	
The 2/11 Medication Administration Record indicated the resident received the Metoporol 25 milligrams daily at 8:00 a.m. 2/1/11 though 2/28/11. The resident's heart rate was not recorded on any of the above		daily at 8:00 a.r 3/24/11. The rewas not recorded dates. The only blood pressure on the 6:00 a.m were on 3/3/11, 3/17/11, and 3/2 The 2/11 Medic Record indicate received the Medaily at 8:00 a.r 2/28/11. The recorded dates are received the Medaily at 8:00 a.r 2/28/11. The recorded dates are received the Medaily at 8:00 a.r 2/28/11. The recorded dates are received the Medaily at 8:00 a.r 2/28/11.	m. 3/1/11 through esident's heart rate ed on any of the above y dates the resident's reading was recorded n. to 2:00 p.m. shifts 3/7/11, 3/14/11, 21/11. eation Administration ed the resident etoporol 25 milligrams m. 2/1/11 though esident's heart rate			Committee meeting for 6 mon- Plan to be amended as indicar per monthly review per PI Committee. Threshold of compliance will be 95% before discontinuing audits. The DON is responsible for ensuring ongoing compliance.	ted		
dates. The only dates the resident's blood pressure reading was recorded on the 6:00 a.m. to 2:00 p.m. shifts were on 2/3/11, 2/7/11, 2/10/11, 2/24/11, and 2/28/11.		dates. The only blood pressure on the 6:00 a.m were on 2/3/11,	y dates the resident's reading was recorded n. to 2:00 p.m. shifts 2/7/11, 2/10/11,						
When interviewed on 3/24/11 at 3:20 p.m., the Director of Nursing indicated the resident's heart rate and blood pressure should have been taken prior to the administration of the medication as ordered by the physician. 3.1-48(a)(3)		p.m., the Direct the resident's h pressure should prior to the adm medication as of physician.	or of Nursing indicated eart rate and blood d have been taken ninistration of the						
3.1-48(a)(4) The facility must ensure that residents are free of any significant medication errors.	F0333	The facility must e							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION ((X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155344	B. WIN			03/28/2	011
		<u> </u>	F1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			HIGHWAY 20 EAST		
	RE CENTER OF MI	CHIGAN CITY		MICHIG	GAN CITY, IN46360		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	· · · · · · · · · · · · · · · · · · ·		DATE
SS=D		rd review and interview,	F0	333	F333 Resident #85 insulin order was	2	04/27/2011
		d to ensure residents			clarified on 01/24/11.	,	
		free of significant			2 .) All residents have the		
		ors related to the			potential to be affected by the		
		of insulin as ordered			same deficient practices. All		
		n for 1 of 10 residents			diabetic residents who are at r for medication errors will have	ISK	
	reviewed for ur	•			appropriate sliding scale		
		the sample of 40.			orders.3.) Diabetic sliding scal	e	
	(Resident #85)				audits will be conducted week		
					by DON/Designee. Licensed		
	Findings includ	e:			nursing staff was in-serviced o		
					03/28/11, 04/06/11 and 04/12/ by Nursing Administration	11	
	The record for	Resident #85 was			regarding getting proper sliding	a	
	reviewed on 3/2	22/11 at 3:11 p.m. The			scale orders and calling physic		
	resident was fir	rst admitted to the			for blood sugars out of		
	facility on 12/3	1/10. The resident was			parameters.4.) Results of thes	е	
	sent to the hos	pital on 1/2/11 and was			audits will be presented at the monthly PI Committee Meeting	,	
	readmitted to th	ne facility on 1/4/11.			for 6 months. Plan to be	9	
	The resident's	diagnoses included,			amended as indicated per		
	but were not lin	nited to, diabetes			monthly review per PI Commit		
	mellitus and ac	ute pancreatitis.			· · · · · · · · · · · · · · · · · · ·	е	
		·			,	:hla	
	Review of the 1	1/4/11 re admission			l · · · · · · · · · · · · · · · · · · ·	เทเษ	
	physician order	rs indicated there was			compliance.Compliance date		
	' '				04/27/11.		
		-					
	,	_					
	•	• .					
	· •						
		• '					
	_	•					
		•					
	_	1 1-10 0 drints to be					
	-	150-199 - 1 units of					
	The resident's obut were not line mellitus and acceptance of the 1 physician order an order for statchecks (test to level) before magoing to sleep. physician's ordereceive Novoling sliding scale. It is scale insuling to Blood glucose given	diagnoses included, nited to, diabetes eute pancreatitis. 1/4/11 re admission			amended as indicated per monthly review per PI Commit Threshold of compliance will b 95% before discontinuing audits.5.) The DON is respons for ensuring ongoing compliance.Compliance date	е	

000236

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155344	B. WIN	G		03/28/2011
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	!
TWINE OF T	NO VIDER OR BUTTELLA			802 US	HIGHWAY 20 EAST	
LIFE CAF	RE CENTER OF MI	CHIGAN CITY		MICHIG	GAN CITY, IN46360	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
	Novolin R insul	_				
		200-249 - 3 units of				
	Novolin R insul	_				
	_	250-299 - 5 units of				
	Novolin R insul	_				
		an for blood glucose				
	level above 300	J.				
	A nhveician's o	rder was written on				
		all the physician				
		d glucose level was				
		0. There were no				
	•	o change the sliding				
		verage at this time.				
		verage at this time.				
	A physician's o	rder was written on				
		ige the sliding scale				
	insulin coverag					
	Accu checks be	efore meals and at				
	night with slidin	g scale coverage with				
	Novolin R insul	in:				
	Blood glucose	1-149 - 0 units to be				
	given					
	Blood glucose	150-199 - 1 units of				
	Novolin R insul	in to be given				
	Blood glucose	200-249 - 3 units of				
	Novolin R insul	in to be given				
	Blood glucose	250-299 - 5 units of				
	Novolin R insul	in to be given				
	Blood glucose	300 and greater - 10				
	units of Novolin	R insulin to be given.				
	Notify physiciar	n of blood glucose level				
	of 400 or greate	_				
	The January 20	011 Glucometer Flow				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND FLAN	OF CORRECTION	155344		LDING	00	03/28/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY		1	GAN CITY, IN46360		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		ewed. The following					J.H.E
		evels were recorded:					
	1/20/11 at lunch						
	1/21/11 at lunch	ո։ 319					
	1/22/11 at lunch	n: 307					
		ation Administration					
	Record indicate						
		s of Novolin R insulin at					
		/20/11, 1/21/11, and hysician's order for					
	•	icated the ordered					
		ly was to cover blood					
	glucose levels i	•					
	3	•					
	When interview	red on 3/25/11 at 11:00					
	a.m., the Direct	or of Nursing indicated					
		nysician's order for the					
	amount of cove	_					
		r blood glucose levels					
		1/11/11 through					
	1/24/11.						
	3.1-48(c)(2)						
F0431		mploy or obtain the					
		sed pharmacist who em of records of receipt					
	and disposition of	all controlled drugs in					
		enable an accurate					
	· ·	determines that drug er and that an account of all					
	controlled drugs is						
	periodically recond						
	Drugs and biologic	cals used in the facility must					
		rdance with currently					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	ETED
		155344	B. WING		- 	03/28/2	011
			p. Wate		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			802 US	HIGHWAY 20 EAST		
	RE CENTER OF MI	CHIGAN CITY		MICHIG	SAN CITY, IN46360		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
	the appropriate ac instructions, and the applicable.	onal principles, and include cessory and cautionary he expiration date when					
	in locked compart temperature contr	ore all drugs and biologicals ments under proper ols, and permit only nel to have access to the					
	permanently affixe storage of controll II of the Comprehe Prevention and Codrugs subject to a facility uses single distribution system stored is minimal a readily detected.	erovide separately locked, and compartments for ed drugs listed in Schedule ensive Drug Abuse control Act of 1976 and other buse, except when the e unit package drug and in which the quantity and a missing dose can be					
SS=E	and interview, to ensure multi do tuberculin were recommended on two medicate medication room potential to affer resided on the \$500 units and for resided on the \$468 and \$48) (The cart) (The 200/s)	rvation, record review, the facility failed to use vials of insulins and a not stored past the dates for medications ion carts and 1 of 2 ms. This had the act 69 residents who 200, 300, 400, and or 20 residents who 100 unit.(Residents the 100 hall Medication 300/400/500 hall m) (The 500 hall	F04	31	Residents #68 and #8 insulin vidiscarded and new insulin received. The TB solution was also discarded. All residents have the potentia be affected by the same deficie practice. All expired TB and insulin vials were discarded. Insulin/TB vials will be audited weekly for expiration dates. Licensed nursing staff was in-serviced on 03/28/11, 04/06 and 04/12/11 by Nursing Administration regarding disposing of TB/Insulin vials af 28 days. Results of these audits will be presented at the monthly PI Committee Meeting for 6 month.	I to ent /11	04/27/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: V9QC11 Facility ID:

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If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SUR	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETE	
		155344	B. WIN			03/28/2011	
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
1.155.041		OLUGAN OLTV		1	HIGHWAY 20 EAST		
LIFE CAR	RE CENTER OF MI	CHIGAN CITY		MICHIG	GAN CITY, IN46360		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E CO	OMPLETION
IAG		· · · · · · · · · · · · · · · · · · ·	-	IAG	·	· bd	DATE
TAG	Findings includ The facility pha "Insulin Storage was reviewed of The Director of policy and indic current. The policy indicated Novolin insulin room temperate policy indicated Novolin insulin room temperate 1. Storage of n hall medication 3/25/11 at 10:3 opened vial of I observed in the insulin vial indic ordered to be u The "date open insulin indicated 2/20/11. When interview a.m., RN #2 indi insulins were to	rmacy policy titled e Recommendations" on 3/25/11 at 2:00 p.m. Nursing provided the cated the policy was olicy had a revised ober 23, 2010. The l unopened vials of could be stored at ure for 28 days. The l opened vials of could be stored at		TAG	Plan to be amended as indicated per monthly review per Placommittee. Threshold of compliance will be 95% before discontinuing audits. The DON/SDC are responsible for ensuring ongoing compliant Compliance date 04/27/11.		DATE
	Storage of n hall medication	nedications in the 500 cart was observed on 0 a.m. with the Staff					
	5.25, 1.7 at 17.00	mar are otan					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344		(X2) MU A. BUIL B. WINC	DING	nstruction 00	(X3) DATE S COMPL 03/28/2	ETED	
	PROVIDER OR SUPPLIER		p. witte	STREET A	DDRESS, CITY, STATE, ZIP CODE HIGHWAY 20 EAST FAN CITY, IN46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	unopened vial stored in the cavial of insulin ir ordered to be used to be use	tion room on the west 0/300/400/500 halls in 3/25/11 at 10:54 a.m. Development Nurse. Opened vial of fied Protein Derivative for in the medication of affixed to the box suberculin was first 0/11. The manufacturer fiert indicated the vials carded 30 days after fived on 3/25/11 at 12:24 for of Nursing indicated di unopened vials of fiave been stored for so per the pharmacy fector of Nursing also pened vial of sonly to stored for 30					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	155344	A. BUIL	DING	00	COMPLETED 03/28/2011	
		100044	B. WING	_	DDDEGG GETY GTATE ZID GODE	03/20/2	011
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MIC	CHIGAN CITY			GAN CITY, IN46360		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	1	TAG	DEFICIENCY)		DATE
F0514	each resident in ac professional stand complete; accurate accessible; and sy The clinical record information to iden the resident's asse and services provi	naintain clinical records on accordance with accepted lards and practices that are ely documented; readily estematically organized. I must contain sufficient attify the resident; a record of essments; the plan of care ded; the results of any eening conducted by the					
SS=D	State; and progress Based on observant interviews, ensure follow understanding accurates a cast/splint approximate the completing accurates assessment for reviewed for correcords in the standings included a cast findings included a cast findings included a cast for completing accurate the cast findings included a cast findings included a cast for complaints of the completion of the cast for completions and the cast for cast for cast for cast findings included a cast for completions and the cast for cast f	rvation, record review, the facility failed to p documentation and is completed related to plication and urate joint mobility 2 of 25 residents implete and accurate sample of 40. and #37) e: for Resident #37 was 23/11 at 9:30 a.m. The ilen out of bed on is sent to the hospital of pain and for an ident returned on that to her right arm and to	F0	514	F514 Resident #6 joint mobility assessment was corrected on 03/29/11.Resident #37 no long requires splints, or slings due to residents refusals. All ortho residents have the potential to be affected by the same deficient practice. All join mobility assessments will be updated. All residents with splints/casts were audited for placement. Joint mobility assessments wi be accurately completed week Splint application will be audited daily M-F by DON/Designee. So was in-serviced on 03/28/11, 04/06/11 and 04/12/11 by Nurs Administration regarding accur joint mobility assessments and follow up documentation with fractures. Results of these audits will be presented at monthly PI Committee. Threshold of compliance will be 95% before discontinuing audits. The DON/Designee is	o nt lly. ed Staff sing rate	04/27/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344		LDING IG	00	(X3) DATE COMPL 03/28/2	ETED	
	PROVIDER OR SUPPLIER		802 US	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 20 EAST GAN CITY, IN46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	on that day. The documentation with the cast to	the resident returned		responsible for ensuring ongo compliance. Compliance date 04/27/11		
	progress note of "fell on elbow,	orthopedic physician's dated 7/27/10 indicated complaints of right ce in splint." Follow up				
	dated 7/27/10 i documentation the resident's r returned from t There was no o	sing Progress Notes Indicated there was no Indicated the indicated in in				
	Nursing Progre 7/30/10 and the there was no d	mented entry in ess Notes was on en again on 8/3/10 and ocumentation of what ight arm was placed in.				
	on 3/25/11 at 8 when the resident orthopedic phycast and placed a sling, however	sician he removed the d the resident's arm in er, there was no in the resident's record				
SS=D	2. On 3/23/11	at 7:50 a.m., Resident		F514		04/27/2011

000236

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155344 03/28/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 802 US HIGHWAY 20 EAST LIFE CARE CENTER OF MICHIGAN CITY MICHIGAN CITY, IN46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE #6 was observed sitting up in a wheel Resident #6 joint mobility assessment was corrected on chair in he room. The resident had a 03/29/11.Resident #37 no longer palm protector type splint in place to requires splints, or slings due to the left hand. residents refusals. All ortho residents have the potential to be affected by the On 3/24/11 at 9:32 a.m., the resident same deficient practice. All joint was observed sitting in a wheel chair mobility assessments will be in her room. The resident had the updated. All residents with palm protector in her left hand. MDS splints/casts were audited for (Minimum Data Set) Nurse #2 opened placement. Joint mobility assessments will the palm protector that was in the be accurately completed weekly. resident's hand. The resident was not Splint application will be audited able to open the last three fingers of daily M-F by DON/Designee. Staff her left hand on her own. The MDS was in-serviced on 03/28/11, Nurse then performed passive range 04/06/11 and 04/12/11 by Nursing Administration regarding accurate of motion and was not able to fully joint mobility assessments and open (extend) the three fingers on follow up documentation with the resident's left hand. fractures. Results of these audits will be presented at monthly PI When interviewed at this time, the Committee. Threshold of MDS Nurse indicated the resident had compliance will be 95% before only moderate extension of these discontinuing audits. fingers at this time. The MDS Nurse The DON/Designee is also indicated when she completed responsible for ensuring ongoing compliance. Compliance date the 2/16/11 Joint Mobility Assessment 04/27/11 she incorrectly at that time. The record for Resident #6 was reviewed on 3/23/11 at 8:04 a.m. The resident's diagnoses included, but were not limited to, syncope, polymyalgia rheumatica, right bundle branch block, high blood pressure, and muscle weakness.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	155344	A. BUILDING	00	COMPLETED 03/28/2011
		100044	B. WING	FADDRESS CITY STATE ZID CODE	00/20/2011
NAME OF P	PROVIDER OR SUPPLIER			FADDRESS, CITY, STATE, ZIP CODE S HIGHWAY 20 EAST	
LIFE CAF	RE CENTER OF MIC	CHIGAN CITY		IGAN CITY, IN46360	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICE (CT)	DATE
	•	cian Order Statement was an order for the			
		r a left hand splint at			
		t during care. The			
	-	obility Assessment			
	indicated the re	•			
		range of motion on the			
		the right and left			
	hands.	C			
	When interview	ed on 3/28/11 at 8:28			
	a.m., the Direct	or of Nursing indicated			
	the resident had	d a contracture to the			
	•	usly and a splint had			
		n 2010. The Director			
	of Nursing indic				
		on the 2/16/11 Joint			
	Mobility Assess	ment was inaccurate.			
	0.4.50(-)(4)				
	3.1-50(a)(1)				
	3.1-50(a)(2)				
				1	
F9999					
	STATE FINDING	GS	F9999	F9999	04/27/2011
				The Staff Development Coordinator will ensure all state	_f
	In addition to the	required inservice hours		receives three (3) hours of	'
		staff who have regular		dementia training annually.	
	contact with resid	dents shall have a		Staff has the potential to be	
	minimum if six (affected by the same deficient practice. All associates lacking	
	-	e training within six (6)		three (3) hours of dementia	,
		employment, or within		training will have one (1) hour	
	thirty (30) days for	or personnel assigned to		dementia training per month u	ntil

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: V9QC11 Facility ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		155344	A. BUILDING 00		00	COMPLETED 03/28/2011	
		199344	B. WIN			03/20/2	011
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
LIFE CA	RE CENTER OF MI	CHIGAN CITY	802 US HIGHWAY 20 EAST MICHIGAN CITY, IN46360				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	-	TAG			DATE
	1	and dementia special care			all asociates are current. Dementia audits will be		
	· ·	3) hours annually		conducted weekly by			
	thereafter to mee				DON/Designee. Staff was		
	1 ^	ooth, of cognitively			in-serviced on 03/28/11, 04/06		
		its to gain understanding			and 04/12/11 on receiving thre		
	of the current sta	andards of care for			(3) hours of dementia training all staff.		
	residents with dementia. This state rule was not met as evidenced				Results of these audits will be presented at the monthly PI		
					Committee Meeting for 6 mon Plan to be amended as indica		
	by: Based on record review and interview the facility failed to ensure the required three (3) hours of dementia specific training was provided annually for 66 of 81 employees who required annual in-service training. (Employees #1 - #66)				per monthly review per PI Committee. Threshold	ieu	
					compliance will be 95% before	۵.	
					discontinuing audits.		
					The DON is responsible for		
					ensuring ongoing compliance. Compliance date 04/27/11.		
	Findings include); 					
	The facility files for Dementia training of						
	1 1	reviewed on 3/28/11 at					
	8:15 a.m. The following employees did not receive three hours of dementia specific training during 2010.						
	Employee #1, A	ctivities staff hired on					
	Employee #2, Activities Supervisor hired on 5/21/07						
		dmissions Coordinator					
	hired on 1/25/01						
		ocial Service Supervisor					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155344		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/28/2011				
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGAN CITY			B. WING 03/23/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 802 US HIGHWAY 20 EAST MICHIGAN CITY, IN46360					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	Supervisor hired Employee #6, As hired on 2/7/00 Employee #7, As Therapist hired on Employee #8, As hired on 11/20/00 Employee #9, Contemployee #9, Contemployee #10, Contemployee #10, Contemployee #10, Contemployee #11, Contemployee #11, Contemployee #12, Contemployee #13, Contemployee #14, Contemployee #15, Contemployee #15, Contemployee #16, Contemployee #16, Contemployee #16, Contemployee #17, Contemployee #18, Contemployee #18, Contemployee #18, Contemployee #18, Contemployee #19, Contemployee #19, Contemployee #19, Contemployee #20, Find on 3/26/01 Employee #21, Find on 10/13/01	ssistant Office Manager ssistant Occupational n 11/28/05 ssistant Speech Therapist retified Occupational at hired on 2/6/03 Sertified Occupational at hired on 2/17/09 Sertified Occupational at hired on 10/11/04 Sook hired on 3/13/00 Sook hired on 9/17/01 Sook hired on 1/11/06 Dietary Aide hired on						

AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		155344	A. BUII		00	03/28/2		
100044			B. WIN		A DDDEGG CITY GTATE ZID CODE	00/20/2	011	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 20 EAST			
LIFE CARE CENTER OF MICHIGAN CITY				1	GAN CITY, IN46360			
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TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		-	TAG	DEFICIENCY)		DATE	
		Rehab Services Manager						
	hired on 9/23/02							
	Employee #24, Laundry Assistant hired on 10/23/03							
	Employee #25, L	Licensed Physical Therapy						
	Assistant hired or	n 6/3/03						
	Employee #26, L	icensed Physical Therapy						
	Assistant hired or							
	* * * *	icensed Physical Therapy						
	Assistant hired on 8/4/09 Employee #28, Licensed Physical Therapy Assistant hired on 6/2/03 Employee #29, LPN hired on 1/28/06 Employee #30, LPN hired on 5/5/09 Employee #31, LPN hired on 10/12/92 Employee #32, LPN hired on 8/2/01							
		LPN hired on 10/15/03						
	Employee #34, LPN hired on 11/9/04 Employee #35, LPN hired on 1/17/94 Employee #36, MDS Coordinator hired on 8/6/92 Employee #37, ADON hired on 1/20/04 Employee #38, Nursing Aide hired on 7/17/06							
	Employee #39, N 9/27/93	Nursing Aide hired on						
		Sursing Aide hired on						
	5/11/04							
	Employee #41, N 9/30/09	Nursing Aide hired on						
		Nursing Aide hired on						
		Nursing Aide hired on						

l '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344	(X2) MU A. BUIL B. WINC	DING	00	(X3) DATE COMPL	ETED	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 802 US HIGHWAY 20 EAST					
LIFE CARE CENTER OF MICHIGAN CITY				MICHIG	AN CITY, IN46360			
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TAG	Employee #44, 14/30/08 Employee #45, 16/15/07 Employee #46, 14/14/09 Employee #47, 19/4/07 Employee #48, 18/26/85 Employee #49, 11/15/05 Employee #50, 11/16/06 Employee #51, 11/16/06 Employee #52, 11/16/06 Employee #53, 11/16/06 Employee #54, 11/16/06 Employee #55, 16/10/08 Employee #56, 03/27/06 Employee #57, 14/26/06 Employee #58, 15/26/06 Employee #58, 16/10/08	Nursing Aide hired on Officer Manager hired on Physical Therapy on 5/22/07 Maintenance Staff hired Maintenance Supervisor		TAG	DEFICIENCY)		DATE	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155344		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING B. WING			LETED			
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	10/15/07 Employee #61, If Employee #62, If Employee #63, If Therapist hired of Employee #64, If Therapist hired of Employee #65, If Therapist hired of Employee #66, If 19/23/02 Interview with the Nurse on 3/28/15 the above employee mployee mploy	Registered Physical on 3/3/09 Registered Physical						